

## **The journal of mental science.**

London : Longman, Green, Longman & Roberts, 1859-1962.

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OF  
MENTAL SCIENCE.

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VOL. LXV.



LONDON :

J. & A. CHURCHILL,  
7, GREAT MARLBOROUGH STREET.

MDCCCXCIX.



" In adopting our title of the *Journal of Mental Science*, published by authority of the Medico-Psychological Association, we profess that we cultivate in our pages mental science of a particular kind, namely, such mental science as appertains to medical men who are engaged in the treatment of the insane. But it has been objected that the term mental science is inapplicable, and that the term mental physiology or mental pathology, or psychology, or psychiatry (a term much affected by our German brethren), would have been more correct and appropriate; and that, moreover, we do not deal in mental science, which is properly the sphere of the aspiring metaphysical intellect. If mental science is strictly synonymous with metaphysics, these objections are certainly valid; for although we do not eschew metaphysical discussion, the aim of this JOURNAL is certainly bent upon more attainable objects than the pursuit of those recondite inquiries which have occupied the most ambitious intellects from the time of Plato to the present, with so much labour and so little result. But while we admit that metaphysics may be called one department of mental science, we maintain that mental physiology and mental pathology are also mental science under a different aspect. While metaphysics may be called speculative mental science, mental physiology and pathology, with their vast range of inquiry into insanity, education, crime, and all things which tend to preserve mental health, or to produce mental disease, are not less questions of mental science in its practical, that is in its sociological point of view. If it were not unjust to high mathematics to compare it in any way with abstruse metaphysics, it would illustrate our meaning to say that our practical mental science would fairly bear the same relation to the mental science of the metaphysicians as applied mathematics bears to the pure science. In both instances the aim of the pure science is the attainment of abstract truth; its utility, however, frequently going no further than to serve as a gymnasium for the intellect. In both instances the mixed science aims at, and, to a certain extent, attains immediate practical results of the greatest utility to the welfare of mankind; we therefore maintain that our JOURNAL is not inaptly called the *Journal of Mental Science*, although the science may only attempt to deal with sociological and medical inquiries, relating either to the preservation of the health of the mind or to the amelioration or cure of its diseases; and although not soaring to the height of abstruse metaphysics, we only aim at such metaphysical knowledge as may be available to our purposes, as the mechanic uses the formularies of mathematics. This is our view of the kind of mental science which physicians engaged in the grave responsibility of caring for the mental health of their fellow-men may, in all modesty, pretend to cultivate; and while we cannot doubt that all additions to our certain knowledge in the speculative department of the science will be great gain, the necessities of duty and of danger must ever compel us to pursue that knowledge which is to be obtained in the practical departments of science with the earnestness of real workmen. The captain of a ship would be none the worse for being well acquainted with the higher branches of astronomical science, but it is the practical part of that science as it is applicable to navigation which he is compelled to study."—Sir J. C. Bucknill, M.D., F.R.S.

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 1895. Lindell, Emil Wilhelm, M.D., Sweden.  
 1901. Manheimer-Gommès, Dr., 32, Rue de l'Arcade, Paris.  
 1909. Moreira, Dr. Julien, M.D. Bahia, Professor and Director of the National Manicomium of Rio de Janeiro (*Editor of the Brazilian Archives of Psychiatry, etc.*).  
 1886. Parant, M. Victor, M.D., Toulouse.  
 1909. Pilcz, Dr. Alexander (Professor of Psychiatry in the University of Vienna), Superintendent Landessanatorium fur Nerven und Geistes- kranke Steinhof, Vienna.

# MEMBERS OF THE ASSOCIATION.

*Alphabetical List of Members of the Association on December 31st, 1918, with the year in which they joined.*

1900. Abbott, Henry Kingsmill, B.A., M.D.Dub., D.P.H.Irel., Medical Superintendent, Hants County Asylum, Fareham.
1891. Adair, Thomas Stewart, M.D., C.M.Edin., F.R.M.S., Medical Superintendent, Storthes Hall Asylum, Kirkburton, near Huddersfield. (*Hon. Sec. N. and M. Division since 1908.*)
1910. Adam, George Henry, M.R.C.S., L.R.C.P.Lond., Manager and Medical Superintendent, West Malling Place, Kent.
1913. Adams, John Barfield, L.R.C.P.&S.Edin., M.P.C., 119, Redland Road, Bristol.
1868. Adams, Josiah O., M.D.Durh., F.R.C.S.Eng., J.P., 117, Cazenove Road, Stamford Hill, London, N. 16.
1886. Agar, S. Hollingsworth, jun., B.A.Cantab., M.R.C.S.Eng., L.S.A., Hurst House, Henley-in-Arden.
1869. Aldridge, Chas., M.D., C.M.Aber., L.R.C.P.Lond., Bellevue House, Plympton, Devon.
1899. Alexander, Hugh de Maine, M.D., C.M.Edin., Medical Superintendent, Aberdeen City District Asylum, Kingseat, Newmachar, Aberdeen.
1899. Allmann, Dorah Elizabeth, M.B., B.Ch.R.U.I., Assistant Medical Officer, District Asylum, Armagh.
1908. Anderson, James Richard Sumner, M.B., Ch.B.Glas., Senior Assistant Medical Officer, Cumberland and Westmorland Asylum, Garlands, Carlisle.
1898. Anderson, John Sewell, M.R.C.S., L.R.C.P.Lond., Senior Assistant Medical Officer, Hull City Asylum, Willerby, near Hull.
1918. Anderson, William Kirkpatrick, M.B., Ch.B.Glas., Visiting Physician, Eastern District Hospital, Glasgow; 3, Ashton Terrace, Glasgow.
1912. Annandale, James Scott, M.B., Ch.B.Edin., Second Assistant Physician, District Asylum, Murthly, Perth.
1912. Aphorp, Frederick William, M.R.C.S.Eng., L.R.C.P.Edin., M.P.C., Senior Medical Officer, St. George's Retreat, Ravensworth, Burgess Hill.
1904. Archdale, Mervyn Alex., M.B., B.S.Durh., Medical Superintendent, County Mental Hospital, Cambridge.
1905. Archdall, Mervyn Thomas, L.R.C.P.&S.Edin., L.S.A.Lond., Brynn-y-Nenadd Hall, Llanfairfechan, N. Wales.
1918. Archibald, Alexander John, M.B., Ch.B.Glas., Acting Medical Superintendent, Argyll and Bute District Asylum, Lochgilphead, Argyllshire.
1918. Archibald, Madeline, L.R.C.P., L.R.C.S., Assistant Medical Officer, Argyll and Bute District Asylum, Lochgilphead.
1882. Armstrong-Jones, Sir Robert, M.D.Lond., B.S., F.R.C.P., F.R.C.S.Eng., 9, Bramham Gardens, London, S.W. 5 (and Plas Dinas, Carnarvon, North Wales). (*Gen. Secretary from 1897 to 1906.*) (*PRESIDENT, 1906-7.*)
1910. Auden, G. A., M.A., M.D., B.C., D.P.H.Cantab., M.R.C.P.Lond., F.S.A., Medical Superintendent, Educational Offices, Edmund Street, Birmingham.
1891. Aveline, Henry T. S., M.D.Durh., M.R.C.S., L.R.C.P.Lond., M.P.C., Medical Superintendent, County Asylum, Cotford, near Taunton, Somerset. (*Hon. Sec. for S.W. Division, 1905-11.*)
1903. Bailey, William Henry, M.D.Lond., M.R.C.S.Eng., L.S.A., D.P.H.Lond., Featherstone Hall, Southall, Middlesex.
1909. Bain, John, M.A., M.B., B.Ch.Glasg. (address uncommunicated).
1913. Bainbridge, Charles Frederick, M.B., Ch.B.Edin., Assistant Medical Officer, Devon County Asylum, Exeter.
1906. Baird, Harvey, M.D., Ch.B.Edin., Periteau, Winchelsea, Sussex.

1878. Baker, H. Morton, M.B., C.M.Edin., 7, Belsize Square, London, N.W. 3.  
 1888. Baker, John, M.D., C.M.Aberd., Medical Superintendent, State Asylum, Broadmoor, Berks.  
 1916. Ballard, E. F., 13, Lyndhurst Road, Hove, Sussex. (*Deceased.*)  
 1904. Barham, Guy Foster, M.A., M.D., B.C.Cantab., M.R.C.S., L.R.C.P.Lond., Acting Medical Superintendent, Claybury Asylum, Woodford Bridge, Essex.  
 1913. Barkley, James Morgan, M.B., Ch.B.Edin. (Senior Medical Officer, Bracebridge Asylum, Lincolnshire); c/o Dr. J. B. Hunter, Bracebridge Heath, Lincoln.  
 1910. Bartlett, George Norton, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, City Asylum, Exeter.  
 1901. Baskin, J. Loughheed, M.D.Brux., L.R.C.P.&S.Edin., L.R.F.P.&S.Glas.  
 1902. Baugh, Leonard D. H., M.B., Ch.B.Edin., The Pleasaunce, York.  
 1874. Beach, Fletcher, M.B., F.R.C.P.Lond., *formerly Medical Superintendent, Darenth Asylum, Dartford*; Cane Hill, Coulsdon, Surrey. (*Secretary Parliamentary Committee, 1896-1906. General Secretary, 1889-1896. PRESIDENT, 1900.*)  
 1892. Beadles, Cecil F., M.R.C.S., L.R.C.P.Lond., Gresham House, Egham Hill, Egham.  
 1902. Beale-Browne, Thomas Richard, M.R.C.S.Eng., L.R.C.P.Lond., c/o P.M.O. Lagos, Nigeria, West Africa.  
 1913. Bedford, Percy William Page, M.B., Ch.B.Edin., County Asylum, Lancaster.  
 1909. Beeley, Arthur, M.Sc.Leeds, M.D., B.S.Lond., M.R.C.S., L.R.C.P.Lond., D.P.H.Camb. (*Assistant Medical Officer, E. Sussex Educational Committee*), Windybank, Kingston Road, Lewes.  
 1914. Bennett, James Wodderspoon, M.R.C.S., L.R.C.P.Lond., Marsden, Ilkley, Yorks.  
 1912. Benson, Henry Porter D'Arcy, M.D., C.M.Edin., M.R.C.P., F.R.C.S. Edin., Medical Superintendent, Farnham House, Finglas, Dublin.  
 1914. Benson, John Robinson, F.R.C.S.Eng., L.R.C.P.Lond., Resident Physician and Proprietor, Fiddington House, Market Lavington, Wilts.  
 1899. Beresford, Edwyn H., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Tooting Bee Asylum, Tooting, London, S.W. 17.  
 1912. Bernecastle, Herbert M., M.R.C.S.Eng., L.R.C.P.Lond., Assistant Medical Officer, Croydon Mental Hospital, Warlingham, Surrey.  
 1894. Blachford, James Vincent, M.D., B.S.Durh., M.R.C.S., L.R.C.P.Lond., M.P.C. (City Asylum, Fishponds, Bristol), Beaufort War Hospital, Bristol.  
 1913. Black, Robert Sinclair, M.A.Edin., M.D., C.M.Aberd., D.P.H., M.P.C., Medical Supt., Pietermaritzburg Mental Hospital, Natal, South Africa.  
 1898. Blair, David, M.A., M.D., C.M.Glasg., County Asylum, Lancaster.  
 1897. Blandford, Joseph John Guthrie, B.A., D.P.H.Camb., M.R.C.S., L.R.C.P.Lond.; Rainhill Asylum, Lancashire.  
 1918. Blandford, Walter Folliott, B.A.Camb., M.R.C.S., L.R.C.P.Lond., Temporary Assistant Medical Officer, Caterham Asylum, Caterham, Surrey.  
 1904. Bodvel-Roberts, Hugh Frank, M.A.Cantab., M.R.C.S., L.R.C.P.Lond., L.S.A., Middlesex County Asylum, Napsbury, near St. Albans, Herts.  
 1900. Bolton, Joseph Shaw, M.D., B.S., D.Sc., F.R.C.P.Lond., Medical Superintendent, West Riding Asylum, Wakefield.  
 1892. Bond, Charles Hubert, D.Sc., M.D., C.M.Edin., M.R.C.P.Lond., M.P.C., Commissioner of the Board of Control, 66, Victoria Street, London, S.W. 1. (*Hon. General Secretary, 1906-12.*)  
 1918. Bower, Cedric William, L.M.S.S.A., Joint Medical Officer, Springfield House, near Bedford.  
 1877. Bower, David, M.D., C.M.Aber., Springfield House, Bedford. (*Chairman Parliamentary Committee, 1907-1910.*)  
 1877. Bowes, John Ireland, M.R.C.S.Eng., L.S.A. (address uncommunicated.)

1917. Bowie, Edgar Ormond, L.A.H.Dub., Dip. Grant Med. Coll. Bombay, L.M.Coombe, Dublin; c/o W. H. Halliburton, Esq., 18, South Frederick Street, Dublin.
1900. Bowles, Alfred, M.R.C.S., L.R.C.P.Lond., 10, South Cliff, Eastbourne.
1896. Boycott, Arthur N., M.D.Lond., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Herts County Asylum, Hill End, St. Albans, Herts. (*Hon. Sec. for S.-E. Division, 1900-05.*)
1898. Boyle, A. Helen A., M.D.Bruce, L.R.C.P.&S.Edin., 9, The Drive, Hove, Brighton.
1883. Boys, A. H., L.R.C.P.Edin., M.R.C.S.Eng., L.S.A.Lond., The White House, St. Albans.
1891. Braine-Hartnell, George M. P., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, County and City Asylum, Powick, Worcester.
1911. Brander, John, M.B., C.B.Edin., Assistant Medical Officer, London County Mental Hospital, Bexley, Kent.
1918. Brend, William Alfred, M.D.Lond., 14, Bolingbroke Grove, London, S.W. 11.
1905. Brown, Harry Egerton, M.D., Ch.B.Glasg., M.P.C., Mental Hospital, Fort Beaufort, Cape Province, S. Africa.
1908. Brown, Robert Cunyngham, M.D., B.S.Durh. (General Board of Lunacy, 25, Palmerston Place, Edinburgh); Administrator, Springburn and Woodside Central Hospital, Glasgow.
1908. Brown, R. Dods, M.D., Ch.B., F.R.C.P., Dipl. Psych., D.P.H.Edin., Medical Superintendent, The Royal Asylum, Aberdeen.
1912. Brown, William, M.D., C.M.Glas., M.P.C., District Medical Officer, Adviser in Lunacy to Bristol Magistrates (1, Manor Road, Fishponds, Bristol); 2nd Southern General Hospital, Southmead, Bristol.
1916. Brown, William, M.A., M.B., B.Ch.Oxon., D.Sc.Lond., Reader in Psychology in the University of London (King's College), (King's College, Strand, London, W.C. 2); Craiglockhart War Hospital, Slateford, Midlothian.
1917. Bruce, Alexander Ninian, M.D., D.Sc., F.R.C.P.E., Lecturer on Neurology, University of Edinburgh, 8, Ainslie Place, Edinburgh.
1893. Bruce, Lewis C., M.D., F.R.C.P.Edin., M.P.C. Medical Superintendent, District Asylum, Druid Park, Murthly, N.B.) (*Co-Editor of Journal 1911-1916; Hon. Sec. for Scottish Division, 1901-1907.*)
1913. Bruntton, George Llewellyn, M.D., Ch.B.Edin., North Riding Asylum, Clifton, York.
1912. Buchanan, William Murdoch, M.B., Ch.B.Glas., Kirklands Asylum, Bothwell, Lanarkshire.
1908. Bullmore, Charles Cecil, J.P., L.R.C.P.&S.Edin., L.R.F.P.&S.Glas., Medical Superintendent, Flower House, Catford, London, S.E. 6.
1912. Burke, J. D., St. Audry's Hospital, Melton, Suffolk.
1911. Buss, Howard Decimus, B.A., B.Sc.France, M.D.Bruce & Cape, M.R.C.S., L.R.C.P., L.M.S.S.A.Lond., Assistant Medical Officer, Fort Beaufort Asylum, Cape Colony.
1910. Cahir, John P., M.B., B.Ch.R.U.I., 198, Camberwell New Road, Camberwell, London, S.E. 5.
1891. Caldecott, Charles, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Earlswood Asylum, Redhill, Surrey.
1913. Cameron, John Allan Munro, M.B., Ch.B.Glas., Pathologist, Scalebor Park Asylum, Burley-in-Wharfedale, Yorks.
1894. Campbell, Alfred Walter, M.D., C.M.Edin., M.P.C., Macquarie Chambers, 183, Macquarie Street, Sydney, New South Wales.
1909. Campbell, Donald Graham, M.B., C.M.Edin., "Auchinellan," 12, Reidhaven Street, Elgin.
1914. Campbell, Finlay Stewart, M.D., C.M.Glas., Deputy Director of Medical Services, Ministry of National Service, Ayr, Scotland.
1880. Campbell, Patrick E., M.B., C.M.Edin., Medical Superintendent, Metropolitan Asylum, Caterham, Surrey.

1897. Campbell, Robert Brown, M.D., C.M., F.R.C.P.E., 6, Abbotsford Crescent, Edinburgh. (*Secretary for Scottish Division from 1910.*)
1905. Carre, Henry, L.R.C.P.&S.Irel., Woodilee Asylum, Lenzie, Glasgow.
1891. Carswell, John, L.R.C.P.Edin., L.R.F.P.&S.Glasg., 43, Moray Place, Edinburgh; Commissioner-General, Board of Control, Scotland.
1874. Cassidy, D. M., M.D., C.M.McGill Coll., Montreal, D.Sc. (Public Health) F.R.C.S.Edin., Medical Superintendent, County Asylum, Lancaster.
1888. Chambers, James, M.A., M.D.R.U.I., M.P.C., The Priory, Roehampton, London, S.W. 15. (*Co-Editor of Journal 1905-1914, Assistant Editor 1900-05.*) (PRESIDENT, 1913-14.) (*Treasurer since 1917.*)
1911. Chambers, Walter Duncan, M.A., M.D., Ch.B.Edin., M.P.C., Crichton Royal Institution, Dumfries.
1865. Chapman, Thomas Algernon, M.D.Glas., L.R.C.S.Edin., F.Z.S., Betula Reigate.
1915. Cheyne, Alfred William Harper, M.B., Ch.B.Aber., Assistant Medical Officer, Royal Asylum, Aberdeen.
1917. Chisholm, Percy, L.R.C.P. & S.Edin., Assistant Medical Officer, Stirling District Asylum, Larbert.
1907. Chislett, Charles G. A., M.B., Ch.B.Glasg., Medical Superintendent, Stonevetts, Chryston, Lanark.
1880. Christie, J. W. Stirling, L.R.C.P.&S.Edin., Medical Superintendent, County Asylum, Stafford.
1878. Clapham, Wm. Crochley S., M.D., F.R.C.P.Ed., M.R.C.S.Eng., F.S.S., The Five Gables, Mayfield, Sussex. (*Hon. Sec. N. and M. Division, 1897-1901.*)
1907. Clarke, Geoffrey, M.D.Lond., Senior Assistant Medical Officer, London County Mental Hospital, Banstead, Sutton, Surrey.
1910. Clarke, James Kilian P., M.B., B.Ch.R.U.I., D.P.H., High Street, Oakham.
1907. Clarkson, Robert Durward, B.Sc., M.D., C.M.Edin., F.R.C.P.Edin. (Medical Officer, Scottish National Institute for the Education of Imbecile Children), The Park, Larbert, Stirling.
1892. Cole, Robert Henry, M.D.Lond., F.R.C.P.Lond., 25, Upper Berkeley Street, London, W.1. (*Secretary of Parliamentary Committee since 1912.*)
1900. Cole, Sydney John, M.A., M.D., B.Ch.Oxon., Medical Superintendent, Wilts County Asylum, Devizes.
1906. Collier, Walter Edgar, M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Kent County Asylum, Maidstone.
1903. Collins, Michael Abdy, M.D., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Ewell War Hospital, Ewell, Surrey. (*Hon. General Secretary, 1912-18.*)
1910. Conlon, Thomas Peter, L.R.C.P.&S.Irel., Resident Medical Superintendent, District Asylum, Monaghan.
1914. Connolly, Victor Lindley, M.B., B.Ch.Belfast, Assistant Medical Officer, Colney Hatch Mental Hospital, London, N. 11.
1910. Coombes, Percival Charles, M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Surrey County Asylum, Netherne.
1905. Cooper, K. D., L.R.C.P.&S.Edin., L.R.F.P.&S.Glas., c/o Leopold & Co. Apollo, Bunder, Bombay.
1903. Cormac, Harry Dove, M.B., B.S.Madras, Medical Superintendent, Cheshire County Asylum, Macclesfield.
1891. Corner, Harry, M.D.Lond., M.R.C.S., L.R.C.P.Lond., M.P.C., 37, Harley Street, London, W.1.
1917. Costello, Christopher, M.B., Assistant Medical Officer, Portrane Asylum, Ireland.
1905. Cotter, James, L.R.C.P.&S.E., L.R.F.P.&S.Glas., Down District Asylum, Downpatrick.
1897. Cotton, William, M.A., M.D.Edin., D.P.H.Cantab., M.P.C., c/o D. N. Cotton, Esq., 9, St. David Street, Edinburgh.



1910. Coupland, William Henry, L.R.C.S.&P.Edin., Medical Superintendent, Royal Albert Institution, Albert House, Haverbreaks, Lancaster.
1913. Court, E. Percy, M.R.C.S., L.R.C.P.Lond., Severalls Asylum, Colchester.
1893. Cowen, Thomas Philip, M.D., B.S. M.R.C.S., L.R.C.P.Lond., Medical Superintendent, County Asylum, Rainhill, Lancashire.
1911. Cox, Donald Maxwell, M.R.C.S., L.R.C.P.Lond., 2, Royal Park, Clifton, Bristol.
1918. Cox, Francis Michael, M.D., F.R.C.P.L., Physician, St. Vincent's Hospital, Dublin; Lord Chancellor's Consulting Visitor in Lunacy for County and City of Dublin; 26, Merriion Square, Dublin.
1893. Craig, Maurice, M.A., M.D., B.C.Cantab., F.R.C.P.Lond., M.P.C., 87, Harley Street, London, W. 1. (*Hon. Secretary of Educational Committee, 1905-8; Chairman of Educational Committee since 1912.*)
1897. Cribb, Harry Gifford, M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Winterton Asylum, Ferryhill, Durham.
1911. Crichlow, Charles Adolphus, M.B., Ch.B.Glas. Roxburgh District Asylum, Melrose.
1917. Crocket, James, M.D.Edin., D.P.H., Medical Superintendent, Colony of Mercy for Epileptics, Consumption Sanatoria of Scotland, Craigielea, Bridge of Weir.
1914. Crookshank, Francis Graham, M.D., M.R.C.P.Lond., 15, Harley Street, London, W. 1.
1904. Cross, Harold Robert, L.S.A.Lond., F.R.G.S., Storthes Hall Asylum, Kirkburton, near Huddersfield.
1915. Crosthwaite, Frederick Douglas, M.B., Ch.B.Edin., D.P.H.Cantab., Assistant Physician, Pretoria Mental Hospital, South Africa.
1914. Cruickshank, J., M.D., Ch.B.Glas., Pathologist, Crichton Royal Hospital, Dumfries.
1907. Daniel, Alfred Wilson, B.A., M.D., B.C.Cantab., M.R.C.S., L.R.C.P.Lond., Acting Medical Superintendent, London County Mental Hospital, Hanwell, London, W. 7.
1896. Davidson, Andrew, M.D., C.M.Aber., M.P.C., Wyoming, Macquarie Street, Sydney, N.S.W.
1914. Davies, Laura Katherine, M.B., Ch.B.Edin., Pathologist and Assistant Medical Officer, Edinburgh City Asylum, Bangour, Dechmont, Linlithgowshire.
1891. Davis, Arthur N., L.R.C.P.&S.Edin., Medical Superintendent, County Asylum, Exminster, Devon.
1894. Dawson, William R., B.A., M.D., B.Ch.Dubl., F.R.C.P.I., D.P.H., Inspector of Lunatics in Ireland, 7, Ailesbury Road, Dublin. (*Hon. Sec. to Irish Division, 1902-11; PRESIDENT, 1911-12.*)
1901. De Steiger, Adèle, M.D.Lond., County Asylum, Brentwood, Essex.
1905. Devine, Henry, M.D., B.S., M.R.C.P.Lond., M.R.C.S.Eng., M.P.C., Medical Superintendent, The Asylum, Milton, Portsmouth. (*Assistant Editor of the Journal since 1916.*)
1904. Devon, James, L.R.C.P. & S.Edin., 1, North Park Terrace, Hillhead, Glasgow.
1903. Dickson, Thomas Graeme, L.R.C.P. & S.Edin., The Merse Cottage, Bakewell, Derbyshire.
1915. Dillon, Frederick, M.B., Ch.B.Edin. (Clinical Assistant, West End Hospital for Nervous Diseases; Assistant Medical Officer, Northumberland House, Green Lanes, Finsbury Park, London, N. 4); Craighen-hall, Falkirk, N.B.
1909. Dillon, Kathleen, L.R.C.P.&S.I., Assistant Medical Officer, District Asylum, Mullingar.
1905. Dixon, J. Francis, M.A., M.D., B.Ch.Dubl., M.P.C., Medical Superintendent, Borough Mental Hospital, Humberstone, Leicester.
1879. Dodds, William J., M.D., C.M., D.Sc.Edin., Glencoil, Bellahouston, Glasgow.

1908. Donald, Robert, M.D., Ch.B.Glas., 3, Gilmour Street, Paisley.
1889. Donaldson, William Ireland, B.A., M.D., B.Ch.Dubl., Medical Superintendent, London County Mental Hospital, Cane Hill, Coulsdon, Surrey.
1892. Donelan, John O'Connor, L.R.C.P.&S.I., M.P.C., St. Dymphna's, North Circular Road, Dublin (Med. Supt., Richmond Asylum, Dublin).
1890. Douglas, William, M.D.R.U.I., M.R.C.S.Eng., F.R.G.S., Brandfold, Goudhurst, Kent.
1905. Dove, Augustus Charles, M.D., B.S.Durh., M.R.C.S.Eng., "Brightside," Crouch End Hill, London, N. 2.
1897. Dove, Emily Louisa, M.B.Lond., 11, Jenner House, Hunter Street, Brunswick Square, London, W.C. 1.
1910. Downey, Michael Henry, M.B., Ch.B.Melb., L.R.C.P. & S. Edin., L.R.F.P. & S. Glasg., Medical Superintendent, Parkside Asylum, Adelaide, South Australia.
1884. Drapes, Thomas, M.B.Dubl., L.R.C.S.I., Medical Superintendent, District Asylum, Enniscorthy, Ireland. (PRESIDENT-ELECT, 1910-11; *Co-Editor of Journal since 1912.*)
1916. Drummond, William Blackley, M.B., C.M.Edin., F.R.C.P., Medical Superintendent, Baldovan Institution, Dundee.
1907. Dryden, A. Mitchell, M.B., Ch.B.Edin., Senior A.M.O., Woodilee Mental Hospital, Lenzie.
1902. Dudgeon, Herbert Wm., M.D., B.S.Durh., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Khanka Government Asylum, Egypt.
1899. Dudley, Francis, L.R.C.P.&S.I., Senior Assistant Medical Officer, County Asylum, Bodmin, Cornwall.
1915. Duff, Thomas, L.R.C.P., L.R.C.S. Edin., L.R.F.P. & S. Glasg., Collington Rise, Bexhill-on-Sea.
1917. Dunn, Edwin Lindsay, M.B., B.Ch.Dub., Medical Superintendent, Berks County Asylum, Wallingford, Berks.
1903. Dunston, John Thomas, M.D., B.S.Lond., Medical Superintendent, West Koppies Asylum, Pretoria, South Africa.
1911. Dykes, Percy Armstrong, M.R.C.S., L.R.C.P.Lond., c/o Messrs. Holt and Co., 3, Whitehall Place, London, S.W. 1.
1899. Eades, Albert I., L.R.C.P. & S.I., Medical Superintendent, North Riding Asylum, Clifton, Yorks.
1906. Eager, Richard, M.D., Ch.B.Aber., M.P.C., Assistant Medical Officer, The Devon Mental Hospital, Exminster.
1881. Earle, Leslie M., M.D., C.M.Edin., 108, Gloucester Terrace, Hyde Park, London, W. 2.
1891. Earls, James Henry, M.D., M.Ch.R.U.I., D.P.H., L.S.A.Lond., M.P.C., Barrister-at-Law, Fenstanton, Christchurch Road, Streatham Hill, London, S.W. 2.
1907. East, Wm. Norwood, M.D.Lond., M.R.C.S., L.R.C.P.Lond., M.P.C., H.M. Prison, Manchester; 17, Walton Park, Liverpool.
1895. Easterbrook, Charles C., M.A., M.D., F.R.C.P.Ed., M.P.C., J.P., Physician Superintendent, Crichton Royal Institution, Dumfries.
1914. Eder, M. D., B.Sc.Lond., M.R.C.S., L.R.C.P.Lond. (Medical Officer, Deptford School Clinic), 37, Welbeck Street, London, W. 1.
1895. Edgerley, Samuel, M.A., M.D., C.M.Edin., M.P.C., Medical Superintendent, West Riding Asylum, Menston, nr. Leeds.
1897. Edwards, Francis Henry, M.D.Bru., M.R.C.P.Lond., M.R.C.S.Eng., Medical Superintendent, Cumberwell House, London, S.E. 5.
1901. Elgee, Samuel Charles, L.R.C.P.&S.I. (Colney Hatch Mental Hospital, New Southgate). The Manor (County of London) War Hospital, Epsom, Surrey.
1898. Elkins, Frank Ashby, M.D., C.M.Edin., M.P.C., Medical Superintendent, Metropolitan Asylum, Leavesden, Herts.
1912. Ellerton, John Frederick Heise, M.D.Bru., M.R.C.S.Eng., L.R.C.P. Edin., Rotherwood, Leamington Spa.



1917. Ellis, Vincent C., M.B., Assistant Medical Officer, Portrane Asylum, Ireland.
1908. Ellison, Arthur, M.R.C.S., L.R.C.P. Eng., Deputy Medical Officer, H.M. Prison, Leeds, 120, Domestic Street, Holbeck, Leeds.
1899. Ellison, F. C., B.A., M.D., B.Ch.Dub., Resident Medical Superintendent, District Asylum, Castlebar.
1911. Emslie, Isabella Galloway, M.D., Ch.B.Edin., West House, Royal Asylum, Morningside, Edinburgh.
1911. English, Ada, M.B., B.Ch.R.U.I., Assistant Medical Officer, District Asylum, Ballinasloe.
1901. Erskine, Wm. J. A., M.D., C.M.Edin., Medical Superintendent, County Asylum, Whitecroft, Newport, I. of W.
1895. Eurich, Frederick Wilhelm, M.D., C.M.Edin., 8, Mornington Villas, Maningham Lane, Bradford.
1894. Eustace, Henry Marcus, B.A., M.D., B.Ch.Dubl., M.P.C., Medical Superintendent, Hampstead and Highfield Private Asylum, Glasnevin, Dublin.
1909. Eustace, William Neilson, L.R.C.S. & P.Irel., Lisronagh, Glasnevin, Co. Dublin.
1918. Evans, A. Edward, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., D.P.H. Liverp., Inspector, Board of Control, 3, Rotherwick Court, Golders Green, London, N.W. 4.
1909. Evans, George, M.B.Lond., Senior Assistant Medical Officer, Severalls Asylum, Colchester.
1918. Evans, Tudor Benson, M.B., Ch.B.Liverp., Lord Derby War Hospital, Warrington. *Home address*: The Pharmacy, Denbigh.
1891. Ewan, John Alfred, M.A. St. And., M.D., C.M.Edin., M.P.C., Greylees, Sleaford, Lincs.
1914. Ewing, Cecil Wilmot, L.R.C.P.I. & L.R.C.S.I. (Second Assistant Medical Officer, Chartham Asylum, near Canterbury), Lord Derby War Hospital, Warrington.
1907. Exley, John, L.R.C.P.I., M.R.C.S. Eng., Medical Officer, H.M. Prison; Grove House, New Wortley, Leeds.
1894. Farquharson, William F., M.D., C.M.Edin., M.P.C., Medical Superintendent, Counties Asylum, Garlands, Carlisle.
1907. Farries, John Stothart, L.R.C.P. & S. Edin., L.R.F.P. & S. Glas., Yrthington, Carlisle.
1917. Fearnside, Edwin Greaves, M.D.Camb., B.C., M.A., 46, Queen Anne Street, Cavendish Square, London, W. 1.
1908. Fennell, Charles Henry, M.A., M.D.Oxon, M.R.C.P.Lond., Reform Club, Pall Mall, London, S.W. 1.
1908. Fenton, Henry Felix, M.B., Ch.B.Edin., Assistant Medical Officer, County and City Asylum, Powick, Worcester.
1907. Ferguson, J. J. Harrower, M.B., Ch.B.Edin., Senior Assistant Medical Officer, Fife and Kinross Asylum, Cupar, Fife.
1906. Fielding, Saville James, M.B., B.S.Durh., Medical Superintendent, Bethel Hospital, Norwich.
1873. Finch, John E. M., M.A., M.D.Cantab., M.R.C.S. Eng., L.S.A.Lond., Holmdale, Stonegate, Leicester.
1889. Finlay, David, M.D., C.M.Glasg., Medical Superintendent, County Asylum, Bridgend, Glamorgan.
1906. Firth, Arthur Marcus, M.A., M.D., B.Ch.Edin., Deputy Medical Superintendent, Barnsley Hall, Bromsgrove, Worcestershire.
1908. Fitzgerald, Alexis, L.R.C.P. & S.I., Medical Superintendent, District Asylum, Waterford.
1888. Fitz-Gerald, Gerald C., B.A., M.D., B.C.Cantab., M.P.C., Medical Superintendent, Kent County Asylum, Chartham, nr. Canterbury.
1908. Fitzgerald, James Francis, L.R.C.P. & S.Irel., Assistant Medical Officer, District Asylum, Clonmel, co. Tipperary, Ireland.
1904. Fleming, Wilfrid Louis Remi, M.R.C.S., L.R.C.P.Lond., Suffolk House, Pirbright, Surrey.
1894. Fleury, Eleonora Lilian, M.D., B.Ch.R.U.I., Assistant Medical Officer, Richmond Asylum, Dublin.

1908. Flynn, Thos. Aloysius, L.R.C.P.&S.I., County Asylum, Thorpe, Norwich.
1902. Forde, Michael J., M.D., B.Ch.R.U.I., Assistant Medical Officer, Richmond Asylum, Dublin.
1911. Forrester, Archibald Thomas William, M.D., B.S., M.R.C.S., L.R.C.P. Lond., Senior Assistant Medical Officer, Leicester and Rutland Counties Asylum, Narborough.
1916. Forsyth, Charles Wesley, M.B.Lond., M.R.C.S., L.R.C.P., Assistant Medical Officer, Kesteven County Asylum, Sleaford, Lincs.
1913. Forward, Ernest Lionel, M.R.C.S., L.R.C.P.Lond. (Assistant Medical Officer, The Coppice, Nottingham); 2/2 East Lances] Field Ambulance.
1913. Fothergill, Claude Francis, B.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P. Lond.; Hensol, Chorley Wood, Herts.
1912. Fox, Charles J., M.R.C.S., L.R.C.P.Lond., The Moat House, Alnechurch Birmingham.
1881. Fraser, Donald, M.D., C.M.Glasg., F.R.F.P.S., 13, Royal Terrace West, Glasgow.
1901. French, Louis Alexander, M.R.C.S., L.R.C.P.Lond., "Locksley," Willingdon, Eastbourne.
1902. Fuller, Lawrence Otway, M.R.C.S.Eng., L.R.C.P.Lond., Medical Superintendent, Three Counties' Asylum, Arlesey, Beds.
1914. Gage, John Munro, L.R.C.P.&S.I., M.P.C., Royal Earlswood Institution, Redhill, Surrey.
1906. Gane, Edward Palmer Steward, M.D.Durh., M.R.C.S., L.R.C.P.Lond., Cane Hill Mental Hospital, Coulsdon, Surrey.
1912. Garry, John William, M.B., B.Ch., N.U.I., Assistant Medical Officer Ennis District Asylum, Ireland.
1912. Gavin, Lawrence, M.B., Ch.B.Edin., L.R.C.P.&S.Edin., L.R.F.P.&S. Glasg., Superintendent, Mullingar District Asylum, Ireland.
1896. Geddes, John W., M.B., C.M.Edin., Medical Superintendent, Mental Hospital, Middlesbrough, Yorks.
1892. Gemmel, James Francis, M.B.Glasg., Medical Superintendent, County Asylum, Whittingham, Preston.
1899. Gilfillan, Samuel James, M.A., M.B., C.M.Edin., Medical Superintendent, London County Mental Hospital, Colney Hatch, London, N. 11.
1912. Gill, Eustace Stanley Hayes, M.B., Ch.B.Liverp., Shaftesbury House, Formby, Liverpool.
1889. Gill, Stanley A., B.A.Dubl., M.D.Durh., M.R.C.P.Lond., M.R.C.S.Eng., Shaftesbury House, Formby, Liverpool.
1904. Gillespie, Daniel, M.D. B.Ch.R.U.I., Dipl. Psych. (Wadsley Asylum, near Sheffield); Wharnccliffe War Hospital, Middlewood Road, Sheffield.
1897. Gilmour, John Rutherford, M.B., C.M., F.R.C.P.Edin., M.P.C., Medical Superintendent, West Riding Asylum, Scalebor Park, Burley-in-Wharfedale, Yorks.
1906. Gilmour, Richard Withers, M.B., B.S.Durh., M.R.C.S., L.R.C.P.Lond., Homewood House, West Meon, Hants.
1878. Glendinning, James, M.D.Glasg., L.R.C.S.Edin. Hill Crest, Lansdown Road, Abergavenny.
1897. Good, Thomas Saxty, M.R.C.S.Eng., L.R.C.P.Lond., Medical Superintendent, County Asylum, Littlemore, Oxford.
1889. Goodall, Edwin, M.D., B.S., F.R.C.P.Lond., M.P.C. (Medical Superintendent, City Mental Hospital, Cardiff); The Welsh Metropolitan War Hospital, Whitchurch, nr. Cardiff.
1918. Goodfellow, Thomas Ashton, M.D.Lond., B.Sc., M.R.C.S., L.R.C.P., 60, Palatine Road, West Didsbury, Manchester.
1899. Gordon, James Leslie, M.D., C.M.Aberd. (Medical Superintendent, Fountain Temporary Asylum, Tooting Grove, Tooting Graveney, London, S.W. 17).
1905. Gordon-Munn, John Gordon, M.D.Edin., F.R.S.E., Heigham Hall, Norwich.

1901. Gostwyck, C. H. G., M.B., Ch.B., F.R.C.P.Edin., M.P.C., Dipl. Psych., Stirling District Asylum, Larbert.
1912. Graham, Gilbert Malise, M.B., Ch.B.Edin., R.N., H.M.S. "Emperor of India."
1914. Graham, Norman Bell, B.A., R.U.I., M.B., B.Ch.Belfast, Assistant Medical Officer, District Asylum, Belfast; 24, Ocean Buildings, Belfast.
1894. Graham, Samuel, L.R.C.P.Lond., Resident Medical Superintendent, District Asylum, Antrim.
1918. Graham, Samuel John, L.R.C.P., L.R.C.S.Edin., L.R.F.P.S.Glasg., Resident Medical Superintendent, Villa Colony Asylum, Purdysburn, Belfast.
1908. Graham, William S., M.B., B.Ch.R.U.I., Assistant Medical Officer, Somerset and Bath Asylum, near Taunton.
1915. Graves, T. Chivers, M.B., B.S., B.Sc.Lond., F.R.C.S.Eng., Medical Superintendent, City and County Asylum, Burghill, Hereford.
1916. Gray, Cyril, L.R.C.P.&S.Edin., Gateshead Borough Asylum, Stannington, Newcastle-on-Tyne.
1909. Greene, Thomas Adrian, L.R.C.S.&P.Irel., J.P., Medical Superintendent, District Asylum, Carlow.
1886. Greenlees, T. Duncan, M.D., C.M.Edin., F.R.S.E., Rostrevor, Kirtleton Avenue, Weymouth.
1912. Gresson, Clarence Edward, M.D., Ch.B.Aberd., c/o Messrs. Holt & Co., 3, Whitehall Place, London, S.W. 1.
1915. Grigsby, Hamilton Marie, L.R.C.P.&S.Edin., 79, Victoria Road North, Southsea.
1901. Grills, Galbraith Hamilton, M.D., B.Ch.R.U.I., Dipl. Psych., Medical Superintendent, County Asylum, Chester.
1916. Grimby, Alan F., B.A., M.A., M.D.Trin.Coll.Dublin, B.Ch., B.A.O., L.M.Rot.Dub. (Assistant Medical Officer, St. Edmondsbury, Lucan, Ireland); *R.N.*, H.M.S. "Indomitable," Naval Post Office B, c/o G.P.O., Edinburgh.
1900. Grove, Ernest George, M.R.C.S., L.R.C.P.Lond., Bootham Park, York.
1894. Gwynn, Charles Henry, M.D., C.M.Edin., M.R.C.S.Eng., co-Licensee, St. Mary's House, Whitchurch, Salop.
1894. Halsted, Harold Cecil, M.D.Durh., M.R.C.S., L.R.C.P.Lond., Manor Road, Selsey, Sussex.
1901. Harding, William, M.D.Edin., M.R.C.P.Lond., Medical Superintendent, Northampton County Asylum, Berry Wood, Northampton.
1899. Harmer, W. A., L.S.A., Resident Superintendent and Licensee, Redlands Private Asylum, Tonbridge, Kent.
1904. Harper-Smith, George Hastie, B.A.Cantab., M.R.C.S., L.R.C.P.Lond., (Senior Assistant Medical Officer, Brighton County Borough Asylum, Haywards Heath), May Cottage, Loughton, Essex.
1898. Harris-Liston, L., M.D.Bru., M.R.C.S., L.R.C.P.Lond., L.S.A., Middleton Hall, Middleton St. George, Co. Durham.
1905. Hart, Bernard, M.D.Lond., M.R.C.S.Eng., 29B, Wimpole Street, London, W. 1, and Northumberland House, Finsbury Park, London, N. 4.
1886. Harvey, Bagenal Crosbie, L.R.C.P.&S.Edin., L.A.H.Dubl., Resident Medical Superintendent, District Asylum, Clonmel, Ireland.
1892. Haslett, William John H., M.R.C.S., L.R.C.P.Lond., M.P.C., Resident Medical Superintendent, Halliford House, Sunbury-on-Thames.
1891. Havelock, John G., M.D., C.M.Edin., Little Stodham, Liss, Hants.
1890. Hay, J. F. S., M.B., C.M.Aberd., Inspector-General of Asylums for New Zealand, Government Buildings, Wellington, New Zealand.
1900. Haynes, Horace E., M.R.C.S.Eng., L.S.A., J.P., Littleton Hall, Brentwood, Essex.
1911. Heffernan, P., *I.M.S.*, B.A., M.B., B.Ch.C.U.I.
1916. Henderson, David Kennedy, M.D.Edin., (Senior Assistant Physician, Royal Asylum, Gartnavel, Glasgow); c/o John Henderson and Sons, Solicitors, Dumfries, Scotland.

1905. Henderson, George, M.A., M.B., Ch.B.Edin., 25, Commercial Road, Peckham, London, S.E. 15.
1877. Hetherington, Charles E., B.A., M.B., M.Ch.Dubl., Medical Superintendent, District Asylum, Londonderry, Ireland.
1877. Hewson, R. W., L.R.C.P.&S.Edin., Medical Superintendent, Coton Hill, Stafford.
1914. Hewson, R. W. Dale, L.R.C.P.&S.Edin., L.R.F.P.&S.Glas., Coton Hill Hospital, Stafford.
1912. Higson, William Davis, M.B., Ch.B.Liverp., D.P.H., Deputy Medical Officer, H.M. Prison, Brixton; 7, Clovelly Gardens, Upper Tulse Hill, London, S.W. 2.
1882. Hill, H. Gardiner, M.R.C.S.Eng., L.S.A., Pentillie, Leopold Road, Wimbledon Park, London, S.W. 19.
1914. Hills, Harold William, B.S., M.B., B.Sc.Lond., M.R.C.S., L.R.C.P.Lond.; Lord Derby War Hospital, Warrington.
1907. Hine, T. Guy Macaulay, M.A., M.D., B.C.Cantab., 37, Hertford Street, Mayfair, London, W. 1.
1909. Hodgson, Harold West, M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Severalls Asylum, Colchester.
1908. Hogg, Archibald, M.B., Ch.B.Glas., 54, High Street, Paisley, N.B.
1900. Holländer, Bernard, M.D.Freib., M.R.C.S., L.R.C.P.Lond., 57, Wimpole Street, London, W. 1.
1912. Holyoak, Walter L., M.D., B.S.Lond., 45, Welbeck Street, London, W. 1.
1903. Hopkins, Charles Leighton, B.A., M.B., B.C.Cantab., Medical Superintendent, York City Asylum, Fulford, York.
1918. Horton, Wilfred Winnall, M.D.Edin., Medical Superintendent, Wye House Asylum, Buxton.
1894. Hotchkis, Robert D., M.A.Glasg., M.D., B.S.Durh., M.R.C.S., L.R.C.P.Lond., M.P.C., Renfrew District Asylum, Dykebar, Paisley N.B.
1912. Hughes, Frank Percival, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., The Grove, Pinner, Middlesex.
1900. Hughes, Percy T., M.B., C.M.Edin., D.P.H., Medical Superintendent, Worcestershire County Asylum, Barnesley Hall, Bromsgrove.
1904. Hughes, William Stanley, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Shropshire County Asylum, Bicton Heath, Shrewsbury.
1897. Hunter, David, M.A., M.B., B.C.Cantab., L.S.A., Medical Superintendent, The Coppice, Nottingham. (*Secretary for S.E. Division*, 1910-1913.)
1909. Hunter, Douglas William, M.B., Ch.B.Glasg., Assistant Medical Officer, 10, Hallfield Road, Bradford.
1912. Hunter, George Yeates Cobb, *I.M.S.*, M.R.C.S., L.R.C.P.Lond., M.P.C., c/o Messrs. Grindlay & Co., 54, Parliament Street, London, S.W. 1.
1904. Hunter, Percy Douglas, M.R.C.S., L.R.C.P.Lond., Three Counties Asylum, Arlesey, Beds.
1888. Hyslop, Theo. B., M.D., C.M.Edin., M.R.C.P.E., L.R.C.S.E., F.R.S.E., M.P.C., 5, Portland Place, London, W. 1.
1915. Ingall, Frank Ernest, F.R.C.S.Eng., L.R.C.P.Lond., D.P.H., Tue Brook Villa, Liverpool.
1908. Inglis, J. P. Park, M.B., Ch.B.Edin., Assistant Medical Officer, Caterham Asylum, Caterham, Surrey.
1906. Irwin, Peter Joseph, L.R.C.P.&S.I., Assistant Medical Officer, District Asylum, Limerick.
1914. James, George William Blomfield, M.B., B.S.Lond., c/o 20, Homesgarth, Letchworth, Herts.
1908. Jeffrey, Geo. Rutherford, M.D., Ch.B.Glas., F.R.C.P.E., M.P.C., Medical Superintendent, Bootham Park, York.



1910. Johnson, Cecil Webb, D.S.O., M.B., Ch.B.Vict. ("Cricklewood," East Sheen, London, S.W. 14); 10th Middlesex Regiment, Fort William, Calcutta, India.
1893. Johnston, Gerald Herbert, L.R.C.P.&S.Edin., L.R.F.P.&S.Glas., Brooke House, Upper Clapton, London, N. 5.
1905. Johnston, Thomas Leonard, L.R.C.P.&S.Edin., L.R.F.P.&S.Glas., Medical Superintendent, Bracebridge Asylum, Lincoln.
1912. Johnstone, Emma May, L.R.C.P. & S.Edin., L.R.F.P.&S.Glas., M.P.C., Dipl. Psych., Holloway Sanatorium, Virginia Water, Surrey.
1878. Johnstone, J. Carlyle, M.D., C.M.Glas., Melrose, Roxburgh.
1903. Johnstone, Thomas, M.D., C.M.Edin., M.R.C.P.Lond., Annandale, Harrogate.
1880. Jones, D. Johnston, M.D., C.M.Edin.
1879. Kay, Walter S., M.D., C.M.Edin., M.R.C.S.Eng., The Grove, Starbech, Harrogate.
1886. Keay, John, M.D., C.M.Glasg., F.R.C.P.Edin. (Medical Superintendent, Bangour Village, Uphall, Linlithgowshire); Edinburgh War Hospital, Bangour. (PRESIDENT, 1918.)
1909. Keith, William Brooks, M.B., Ch.B.Aberd., M.P.C., 81st Field Ambulance, 27th Division.
1908. Kelly, Richard, M.D., B.Ch.Dub., Assistant Medical Officer, Storther's Hall Asylum, Kirkburton, near Huddersfield.
1907. Keene, George Henry, M.D., The Asylum, Goodmayes, Ilford, Essex.
1899. Kennedy, Hugh T. J., L.R.C.P.&S.I., Assistant Medical Officer, District Asylum, Enniscorthy, Co. Wexford.
1897. Kerr, Hugh, M.A., M.D.Glasg., Medical Superintendent, Bucks County Asylum, Stone, Aylesbury, Bucks.
1902. Kerr, Neil Thomson, M.B., C.M.Ed., Medical Superintendent, Lanark District Asylum, Hartwood, Shotts, N.B.
1893. Kershaw, Herbert Warren, M.R.C.S.Eng., L.R.C.P.Lond., Dinsdale Park, near Darlington.
1897. Kidd, Harold Andrew, M.R.C.S.Eng., L.R.C.P.Lond. (Medical Superintendent, West Sussex Mental Hospital, Chichester); Graylingwell War Hospital, Chichester.
1916. Kilgariff, Joseph O'Loughlin, A.B., M.B., B.Ch., B.A.O.Univ., Dublin, Assistant Medical Officer, County Asylum, Prestwich, Lancs.
1903. King, Frank Raymond, B.A.Cantab., M.R.C.S.Eng., L.R.C.P.Lond., Medical Superintendent, Peckham House, Peckham, London, S.E.
1902. King-Turner, A. C., M.B., C.M.Edin., The Retreat, Fairford, Gloucestershire.
1915. Kirwan, Richard R., M.B., B.Ch. R.U.I., Assistant Medical Officer, West Riding Asylum, Menston, Leeds.
1915. Kitson, Frederick Hubert, M.B., Ch.B.Leeds, Assistant Medical Officer, West Riding Asylum, Wakefield.
1903. Kough, Edward Fitzadam, B.A., M.B., B.Ch.Dubl., Senior Assistant Medical Officer, County Asylum, Gloucester.
1898. Labey, Julius, M.R.C.S., L.R.C.P., L.S.A.Lond., Medical Superintendent, Public Asylum, Jersey.
1902. Langdon-Down, Percival L., M.A., M.B., B.C.Cantab., Dixland, Hampton Wick, Middlesex.
1896. Langdon-Down, Reginald L., M.A., M.B., B.C.Cantab., M.R.C.P.Lond., Normansfield, Hampton Wick.
1914. Ladell, E. G. Macdonald, M.B., Ch.B.Vict., The Gables, Killinghall, Harrogate.
1909. Laurie, James, M.B., Ch.M.Glasg. (*Medical Officer, Smithston Asylum*), (Red House, Ardgowan Street, Greenock); 3rd Scottish Hospital.
1902. Laval, Evariste, M.B., C.M.Edin., The Guildhall, Westminster, London, S.W. 1.
1898. Lavers, Norman, M.D.Bruce, M.R.C.S., L.R.C.P.Lond. (Medical Superintendent, Bailbrook House, Bath); Red Cross Military Hospital, Moss Side, Maghull, near Liverpool.

1892. Lawless, George Robert, F.R.C.S.I., L.R.C.P.I., Medical Superintendent, District Asylum, Armagh.
1870. Lawrence, Alexander, M.A., M.D., C.M.Aberd., 26, Hough Green, Chester.
1883. Layton, Henry A., M.R.C.S.Eng., L.R.C.P.Edin., 26, Kimbolton Road, Bedford.
1915. Leech, H. Brougham, M.D., B.Ch.Dublin, Assistant Medical Officer, County Asylum, Hatton, Warwick.
1909. Leech, John Frederick Wolseley, M.D., B.Ch.Dubl., Assistant Medical Officer, County Asylum, Devizes, Wilts.
1899. Leeper, Richard R., F.R.C.S.I., L.R.C.P.I., M.P.C., Medical Superintendent, St. Patrick's Hospital, Dublin. (*Hon. Sec. to the Irish Division since 1911.*)
1883. Legge, Richard J., M.D., R.U.I., L.R.C.S.Edin., "Comeragh," Leckhampton Road, Cheltenham.
1906. Leggett, William, B.A., M.D., B.Ch.Dubl., Assistant Medical Officer, Royal Asylum, Sunnyside, Montrose).
1916. Lewis, Edward, L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glasg., Cwirlai, Ty-Cross, Anglesey.
1914. Lindsay, David George, L.R.C.P.&S.Edin., Senior Assistant Medical Officer, Dundee District Asylum, West Green, Dundee.
1908. Littlejohn, Edward Salteine, M.R.C.S., L.R.C.P.Lond., Acting Medical Superintendent, London County Mental Hospital, Cane Hill, Surrey.
1916. Lloyd, Brindley Richard, M.B., B.S.Lond., D.P.H.Lond., Assistant Medical Officer, Monmouthshire Asylum, Abergavenny.
1898. Lord, John R., M.B., C.M.Edin. (Medical Superintendent, Horton Mental Hospital, Epsom); Horton County of London War Hospital, Epsom, Surrey. (*Co-Editor of Journal since 1911; Assistant Editor of Journal, 1900-11.*)
1906. Lowry, James Arthur, M.D., B.Ch., R.U.I., Medical Superintendent, Surrey County Asylum, Brookwood.
1904. Lyall, C. H. Gibson, L.R.C.P.&S.Edin., Leicester Borough Asylum, Leicester.
1872. Lyle, Thomas, M.D., C.M.Glasg., 34, Jesmond Road, Newcastle-on-Tyne.
1906. Macarthur, John, M.R.C.S., L.R.C.P.Lond., (Assistant Medical Officer, Colney Hatch Mental Hospital, London, N. 11); Mediterranean Expeditionary Force.
1880. MacBryan, Henry C., L.R.C.P. & S. Edin., Kingsdown House, Box, Wilts.
1900. McClintock, John, L.R.C.P.&S.Edin., Resident Medical Superintendent, Grove House, All Stretton, Church Stretton, Salop.
1901. MacDonald, James H., M.B., Ch.B., F.R.F.P.&S.Glasg., Govan District Asylum, Hawkhead, Paisley, N.B.
1884. MacDonald, P. W., M.D., C.M.Aberd., Grasmere, Spa Road, Weymouth. (*First Hon. Sec. S.W. Div. 1894 to 1905.*) (PRESIDENT, 1907-8.)
1911. MacDonald, Ranald, M.D., Ch.B.Edin., London County Mental Hospital, Bexley, Kent.
1905. MacDonald, William Fraser, M.B., Ch.B.Edin., M.P.C., 96, Polworth Terrace, Edinburgh.
1905. McDougall, Alan, M.D., Ch.B.Vict., M.R.C.S., L.R.C.P.Lond., Medical Director, The David Lewis Colony, Sandle Bridge, near Alderley Edge, Cheshire.
1911. McDougall, William, M.A., M.B., B.C.Cantab., M.Sc.Vict., 89, Banbury Road, Oxford.
1906. McDowall, Colin Francis Frederick, M.D., B.S.Durh., Medical Superintendent, Ticehurst House, Ticehurst, Sussex.
1870. McDowall, Thomas W., M.D.Edin., L.R.C.S.E., Wadhurst, Ticehurst, Sussex. (PRESIDENT, 1897-8.)
1895. Macfarlane, Neil M., M.D., C.M.Aber., Medical Superintendent, Government Hospital, Thlotse Heights, Leribe, Basutoland, South Africa.
1902. McGregor, John, M.B., Ch.B.Edin., Senior Assistant Medical Officer, County Asylum, Bridgend, Glam.

1917. McIver, Colin, M.R.C.S., L.R.C.P., *I.M.S.*, c/o Messrs. Grindlay & Co., Bombay, India.
1914. Mackay, Magnus Ross, M.D., Ch.B.Edin., British Expeditionary Force, France.
1917. Mackay, Norman Douglas, M.D., B.Sc., D.P.H., Dall-Avon, Aberfeldy, Perthshire.
1915. McKenna, Edward Joseph, M.B., B.Ch., R.U.I., Assistant Medical Officer, Carlow District Asylum.
1911. Mackenzie, John Cosserat, M.B., Ch.B.Edin., County Mental Hospital, Burntwood, near Lichfield.
1891. Mackenzie, Henry J., M.B., C.M.Edin., M.P.C., Assistant Medical Officer, The Retreat, York.
1903. Mackenzie, Theodore Charles, M.D., Ch.B., F.R.C.P.Edin., M.P.C., Medical Superintendent, District Asylum, Inverness.
1914. Macleod, Jan R., L.R.C.P.&S.Edin., L.R.F.P.&S.Glasg., 7, Mayfield Gardens, Edinburgh.
1917. McMaster, Albert Victor, B.A., M.R.C.S.Eng., "The Mount," Hills Road, Cambridge.
1904. Macnamara, Eric Danvers, M.A.Camb., M.D., B.C., F.R.C.P.Lond., 87, Harley Street, London, W. 1.
1914. Macneill, Celia Mary Colquhoun, M.B., Ch.B.Edin. (Pathologist, Northfield, Prestonpans); Leith War Hospital, Seafeld, Leith.
1910. MacPhail, Hector Duncan, M.A., M.D., Ch.B.Edin. (Assistant Medical Officer, City Asylum, Gosforth, Newcastle-on-Tyne); Northumberland War Hospital, Newcastle.
1882. Macphail, S. Rutherford, M.D., C.M.Edin., Derby Borough Asylum, Rowditch, Derby.
1896. Macpherson, Charles, M.D.Glas., L.R.C.P.&S., D.P.H.Edin., Deputy Commissioner in Lunacy, 25, Palmerston Place, Edinburgh.
1901. McRae, G. Douglas, M.D., C.M.Edin., F.R.C.P.Ed., Medical Superintendent, District Asylum, Ayr, N.B. (Assistant Editor of the *Journal* since 1916).
1902. Macrae, Kenneth Duncan Cameron, M.B., Ch.B.Edin. (Bangour Village, Dechmont, Linlithgowshire); M.E.F.
1894. McWilliam, Alexander, M.A., M.B., C.M.Aber., Waterval, Odiham, Winchfield, Hants.
1915. Manifold, Robert Fenton, M.B., D.Ch.Dub., Senior Assistant Medical Officer, Denbigh Asylum, North Wales.
1908. Mapother, Edward, M.D., B.S.Lond., F.R.C.S.Eng., Assistant Medical Officer, London County Mental Hospital, Long-Grove, Epsom.
1903. Marnan, John, B.A., M.B., B.Ch.Dubl., Medical Superintendent, County Asylum, Gloucester.
1896. Marr, Hamilton C., M.D., C.M., F.R.F.P.&S.Glasg., M.P.C., Commissioner in Lunacy (10, Succoth Avenue, Edinburgh). (*Hon. Sec. Scottish Division*, 1907-1910).
1913. Marshall, Robert, M.B., Ch.B.Glas. (Assistant Medical Officer, Gartloch Mental Hospital, Gartcosh, N.B.); 19th General Hospital, British Expeditionary Force.
1905. Marshall, Robert Macnab, M.D., Ch.B.Glasg., M.P.C., 2, Clifton Place, Glasgow.
1908. Martin, Henry Cooke, M.B., Ch.B.Edin., Assistant Medical Officer, Newport Borough Asylum, Caerleon.
1896. Martin, James Charles, L.R.C.S. & P.I., J.P., Assistant Medical Officer, District Asylum, Letterkenny, Donegal.
1908. Martin, James Ernest, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, London County Mental Hospital, Long-Grove, Epsom.
1907. Martin, Mary Edith, L.R.C.P.&S.Edin., L.R.F.P.&S.Glas., L.S.A.Lond., M.P.C.Lond., Bailbrook House, Bath.
1914. Martin, Samuel Edgar, M.B., B.Ch.Edin., Barrister-at-Law (Senior Assistant Medical Officer, St. Andrew's Hospital, Northampton); British Mediterranean Expeditionary Force.



1911. Martin, William Lewis, M.A., B.Sc., M.B., C.M.Edin., D.P.H., M.P.C., Dipl. Psych. (*Certifying Physician in Lunacy, Edinburgh Parish Council*), 56, Bruntsfield Place, Edinburgh.
1911. Mathieson, James Moir, M.B., Ch.B.Aber. (Assistant Medical Officer, Wadsley Asylum, Sheffield); The Wharnccliffe War Hospital, Sheffield.
1904. May, George Francis, M.D., C.M.McGill, L.S.A., Winterton Asylum, Ferryhill, Durham.
1912. Melville, William Spence, M.B., Ch.B.Glas., Woodilee Mental Hospital, Lenzie, Glasgow.
1890. Menzies, William F., M.D., B.Sc.Edin., M.R.C.P.Lond., Medical Superintendent, Stafford County Asylum, Cheddleton, near Leek.
1891. Mercier, Charles A., M.D.Lond., F.R.C.P., F.R.C.S.Eng., late Lecturer on Insanity, Westminster Hospital; Moorcroft, Parkstone, Dorset. (*Secretary Educational Committee, 1893-1905. Chairman do. from 1905-12.*) (PRESIDENT, 1908-9.)
1877. Merson, John, M.A., M.D., C.M.Aber., Medical Superintendent, Borough Asylum, Hull.
1893. Middlemass, James, M.A., M.D., C.M., B.Sc.Edin., F.R.C.P., M.P.C., Medical Superintendent, Borough Asylum, Ryhope, Sunderland.
1910. Middlemiss, James Ernest, M.R.C.S.Eng., L.R.C.P.Lond.; 131, North Street, Leeds.
1883. Miles, George E., M.R.C.S., L.R.C.P.Lond., D Block, Royal Victoria Hospital, Netley, Hants; British Empire Club, St. James' Square, London, S.W. 1.
1887. Miller, Alfred, M.B., B.Ch.Dubl., Medical Superintendent, Hatton Asylum, Warwick. (*Registrar since 1902.*)
1912. Miller, Richard, M.B., B.Ch.Dubl.
1893. Mills, John, M.B., B.Ch., Dipl. Ment. Dis., R.U.I., Medical Superintendent, District Asylum, Ballinasloe, Ireland.
1913. Milner, Ernest Arthur, M.B., C.M.Edin., Assistant Medical Officer, Royal Albert Institution, Lancaster.
1911. Moll, Jan. Marius, Doc. in Arts and Med, Utrecht Univ., L.M.S.S.A. Lond., M.P.C., Box 2587, Johannesburg, South Africa.
1913. Molyneux, Benjamin Arthur, B.A., M.D., B.Ch.Dubl., St. Helens House, St. Helens, Hastings.
1910. Monnington, Richard Caldicott, M.D., Ch.B., D.P.H.Edin. (Darenth Industrial Colony, Dartford, Kent); c/o Rev. T. P. Monnington, Lowick Green, Ulverston, Lancs.
1915. Monrad-Krohn, G. H., M.B., B.S., M.R.C.P.Lond., M.R.C.S.Eng., Assistant Medical Officer, Rikshospitalet, Christiania.
1914. Montgomery, Edwin, F.R.C.S.I., L.R.C.P.I. Dipl. Psych. Manch. (Prestwich Asylum, Lancs.); 77th Field Ambulance, British Expeditionary Force.
1899. Moore, Wm. D., M.D., M.Ch.R.U.I., Medical Superintendent, Holloway Sanatorium, Virginia Water, Surrey.
1914. Morres, Frederick, M.R.C.S.Eng., L.R.C.P.Lond. (Assistant Medical Officer, Cane Hill Mental Hospital, Coulsdon, Surrey); Lord Warden Hotel, Dover.
1917. Morris, Bedlington Howel, M.B., B.S.Durh., Inspector-General of Hospitals, South Australia; Pembroke Street, College Park, St. Peter's, S. Australia.
1896. Morton, W. B., M.D.Lond., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Wonford House, Exeter.
1896. Mott, F. W., M.D., B.S., F.R.C.P.Lond., LL.D.Edin., F.R.S., 25, Nottingham Place, Marylebone, London, W. 1.
1896. Mould, Gilbert E., M.R.C.S., L.R.C.P.Lond., The Grange, Rotherham, Yorks.
1897. Mould, Philip G., M.R.C.S.Eng., L.R.C.P.Lond., Overdale, Whitefield, Manchester.
1914. Moyes, John Murray, M.B., Ch.B.Edin., D.P.M.Leeds, Crichton Royal Institution, Dumfries.
1907. Mules, Bertha Mary, M.D., B.S.Durh., Court Hall, Kenton, S. Devon.

1911. Muncaster, Anna Lilian, M.B., B.Ch.Edin. (County Asylum, Chester); home address, 8, Craylockhail Terrace, Edinburgh; at present serving with Serbian Red Cross Society.
1917. Munro, Robert, M.B., Ch.B.Aberd., Assistant Medical Officer, Dorset County Asylum, Dorchester.
- Murray, Jessie M., M.B., B.S.Durham, 14, Endsleigh Street, Tavistock Square, London, W.C. 1.
1909. Myers, Charles Samuel, M.A., D.Sc., M.D., B.C.Cantab., M.R.C.S., L.R.C.P.Lond., Great Shelford, Cambridgeshire.
1903. Navarra, Norman, M.R.C.S., L.R.C.P.Lond., City of London Mental Hospital, near Dartford, Kent.
1910. Neill, Alexander W., M.D., Ch.B.Edin., Warneford Mental Hospital, Oxford.
1903. Nelis, William F., M.D.Durh., L.R.C.P.Edin., L.R.F.P.&S.Glasg., Medical Superintendent, Newport Borough Asylum, Caerleon, Mon.
1869. Nicolson, David, C.B., M.D., C.M.Aber., M.R.C.P.Edin., F.S.A.Scot., 201, Royal Courts of Justice, Strand, London, W.C. 2. (PRESIDENT, 1895-6.)
1888. Nolan, Michael J., L.R.C.P.&S.I., M.P.C., Medical Superintendent, District Asylum, Downpatrick.
1913. Nolan, James Noël Green, M.B., B.Ch., A.B.Dub., The Hospital, Helingly Asylum, Sussex.
1909. Norman, Hubert James, M.B., Ch.B., D.P.H.Edin., Assistant Medical Officer, Camberwell House Asylum, Peckham Road, London, S.E. 5. (*Home address*: 51, Crystal Palace Park Road, Sydenham, London, S.E. 26.)
1916. O'Carroll, Joseph, M.D., F.R.C.P., Physician Richmond and Whitworth Hospitals; Lord Chancellor's Medical Visitor in Lunacy; 43, Merrion Square, Dublin.
1903. O'Doherty, Patrick, B.A., M.B., B.Ch.R.U.I., District Asylum, Omagh.
1918. Ogilvie, William Mitchell, M.B., C.M.Aberd., Medical Superintendent, Ipswich Mental Hospital, Ipswich.
1901. Ogilvy, David, B.A., M.D., B.Ch.Dub., Medical Superintendent, London County Asylum, Long Grove, Epsom, Surrey.
1911. Oliver, Norman H., M.R.C.S., L.R.C.P.Lond., Barrister-at-Law, Officer in Charge, No. 4 Special Hospital for Officers, Latchmere, Ham Common, Surrey.
1892. O'Mara, Francis, L.R.C.P.&S.I., District Asylum, Ennis, Ireland.
1902. Orr, David, M.D., C.M.Edin., M.P.C., Pathologist, County Asylum, Prestwich, Lancs.
1910. Orr, James H. C., M.D., Ch.B.Edin., Rosslynlee Asylum, Midlothian.
1899. Osburne, Cecil A. P., F.R.C.S., L.R.C.P.Edin., The Grove, Old Catton, Norwich.
1914. Osburne, John C., M.B., B.Ch.Dubl., Assistant Medical Officer, Lindville, Cork.
1890. Oswald, Landel R., M.B., C.M.Glasg., M.P.C., Physician Superintendent, Royal Asylum, Gartnavel, Glasgow.
1916. Overbeck-Wright, Alexander William, M.D., Ch.B., M.P.C., D.P.H., Superintendent, Lunatic Asylum, Agra, U. P., India (at present on military duty); Lecturer on Mental Diseases, King George's Hospital, Lucknow, and Agra Medical School, Agra. *Address* 12, Rubislaw Terrace, Aberdeen.
1905. Paine, Frederick, M.D.Bru., M.R.C.S., M.R.C.P.Lond., Claybury Mental Hospital, Woodford Bridge, Essex.
1898. Parker, William Arnot, M.B., C.M.Glasg., M.P.C., Medical Superintendent, Gartloch Asylum, Gartcosh, N.B.
1898. Pasmore, Edwin Stephen, M.D., M.R.C.P.Lond., Chelsham House, Chelsham, Surrey.

1916. Patch, Charles James Lodge, L.R.C.P.&S.Edin., Assistant Medical Officer, Renfrew District Asylum, Dykebar, Paisley.
1899. Patrick, John, M.B., Ch.B., R.U.I., Medical Superintendent, Tyrone Asylum, Omagh, Ireland.
1907. Peachell, George Ernest, M.D., B.S.Lond., M.R.C.S., L.R.C.P.Lond., M.P.C., Medical Superintendent, Dorset County Asylum, Herrison, Dorchester.
1910. Pearn, Oscar Phillips Napier, M.R.C.S., L.R.C.P., L.S.A.Lond., (Assistant Medical Officer, London County Mental Hospital, Horton, Epsom); Lord Derby's War Hospital, Warrington, Lancs.
1915. Pennant, Dyfrig Huws, D.S.O., M.R.C.S., L.R.C.P.Lond., Barnwood House, Gloucester.
1913. Penny, Robert Augustus Greenwood, M.R.C.S., L.R.C.P.Lond., Devon County Asylum, Exminster.
1893. Perceval, Frank, M.R.C.S., L.R.C.P.Lond., Medical Superintendent, County Asylum, Prestwich, Manchester, Lancashire.
1911. Petrie, Alfred Alexander Webster, M.D., B.S.Lond., Ch.B., F.R.C.S. Edin., Assistant Medical Officer, Epileptic Colony, Epsom.
1878. Philipps, Sutherland Rees, M.D., C.M.Q.U.I., F.R.G.S., Bredon, Fisher Street, Paignton.
1908. Phillips, John George Porter, M.D., B.S.Lond., M.R.C.S., M.R.C.P.Lond., M.P.C., Resident Physician and Superintendent, Bethlem Royal Hospital, Lambeth, London, S.E. 1. (*Secretary of Educational Committee since 1912.*)
1910. Phillips, John Robert Parry, M.R.C.S., L.R.C.P.Lond. (Assistant Medical Officer, City Asylum, Bristol); Beaufort War Hospital, Bristol.
1906. Phillips, Nathaniel Richard, M.D.Brux., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, County Asylum, Abergavenny, Monmouthshire.
1905. Phillips, Norman Routh, M.D.Brux., M.R.C.S., L.R.C.P.Lond., 67, Billing Road, Northampton.
1891. Pierce, Bedford, M.D., F.R.C.P.Lond., Medical Superintendent, The Retreat, York. (*Hon. Secretary N. and M. Division 1900-8.*) (PRESIDENT-ELECT.)
1888. Pietersen, J. F. G., M.R.C.S., L.R.C.P.Lond., Ashwood House, Kingswinford, near Dudley, Stafford.
1896. Planck, Charles, M.A.Camb., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Brighton County and Borough Asylum, Haywards Heath.
1912. Plummer, Edgar Curnow, M.R.C.S., L.R.C.P.Lond. (Medical Superintendent, Laverstock House, Salisbury); British Expeditionary Force.
1889. Pope, George Stevens, L.R.C.P.&S.Edin., L.R.F.P.&S.Glasg., Medical Superintendent, Somerset and Bath Asylum, "Westfield," near Wells, Somerset.
1913. Potts, William A., M.A.Camb., M.D.Edin.&Birm., M.R.C.S., L.R.C.P.Lond., *Medical Officer to the Birmingham Committee for the Care of the Feeble-minded*, 118, Hagley Road, Birmingham.
1876. Powell, Evan, M.R.C.S.Eng., L.S.A., Medical Superintendent, City Lunatic Asylum, Nottingham.
1910. Powell, James Farquharson, M.R.C.S., L.R.C.P., D.P.H.Lond., M.P.C., Assistant Medical Officer, The Asylum, Caterham, Surrey.
1916. Power, Patrick William, L.R.C.P., L.R.C.S., Senior Assistant Medical Officer, County Asylum, Chester.
1908. Prentice, Reginald Wickham, L.M.S.S.A.Lond., Beauworth Manor, Alresford, Hants.
1918. Prideaux, John Joseph Francis Engledue, M.R.C.S., L.R.C.P.Lond., Resident Medical Officer, Graylingwell War Hospital, Chichester.
1901. Pugh, Robert, M.D., Ch.B.Edin., Medical Superintendent, Brecon and Radnor Asylum, Talgarth, S. Wales.
1904. Race, John Percy, M.R.C.S., L.R.C.P., L.S.A.Lond., Journals and notices to Winterton Asylum, Ferryhill, Durham (Wheatley Hill, Doncaster).

1899. Rainsford, F. E., M.D., B.A.Dubl., L.R.C.P.I., L.R.C.P.&S.E., Resident Physician, Stewart Institute, Palmerston, co. Dublin.
1894. Rambaut, Daniel F., M.A., M.D., B.Ch.Dub., Medical Superintendent, St. Andrew's Hospital, Northampton.
1910. Rankine, Surg. Roger Aiken, R.N., M.B., B.S., M.R.C.S., L.R.C.P.Lond., M.P.C.
1889. Raw, Nathan, M.P., M.D., B.S.Durh., L.S.Sc., F.R.C.S.Edin., M.R.C.P. Lond., M.P.C. (66, Rodney Street, Liverpool); Liverpool Merchants' Hospital, A.P.O.S. 11, British Exped. Force, France.
1870. Rayner, Henry, M.D.Aberd., M.R.C.P.Edin., Upper Terrace House, Hampstead, London, N.W. 3. (PRESIDENT, 1884.) (*General Secretary*, 1887-89.) (*Co-Editor of Journal* 1895-1911.)
1913. Read, Charles Stanford, M.B.Lond., M.R.C.S., L.R.C.P.Lond. (Assistant Medical Officer, Fisherton House, Salisbury); Royal Victoria Hospital, Netley.
1903. Read, George F., L.R.C.S.&P.Edin., Hospital for the Insane, New Norfolk, Tasmania.
1899. Redington, John, F.R.C.S.&L.R.C.P.I., Portrane Asylum, Donabate, Co. Dublin.
1911. Reeve, Ernest Frederick, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Senior Assistant Medical Officer, County Asylum, Rainhill, Lancs.
1911. Reid, Daniel McKinley, M.D., Ch.B.Glasg., Royal Asylum, Gartnavel, Glasgow.
1910. Reid, William, M.A.St. And., M.B., Ch.B.Edin., Senior Assistant Medical Officer, Burntwood Asylum, Lichfield.
1886. Revington, George T., M.A., M.D., B.Ch.Dubl., M.P.C., Medical Superintendent, Central Criminal Asylum, Dundrum, Ireland.
1899. Rice, David, M.D.Bruce., M.R.C.S., L.R.C.P.Lond., D.P.H., Medical Superintendent, City Asylum, Hillesdon, Norwich.
1897. Richard, William J., M.A., M.B., Ch.M.Glasg., Merryflats, Govan, Glasgow.
1899. Richards, John, M.B., C.M.Edin., F.R.C.S.E., Medical Superintendent, Joint Counties Asylum, Carmarthen.
1911. Robarts, Henry Howard, M.D., Ch.B.Edin., D.P.H.Glasg., Ennerdale, Haddington, Scotland.
1914. Roberts, Ernest Theophilus, M.D., C.M.Edin., D.P.H.Camb., M.P.C., Hawkstone, 58, South Brae Drive, Jordanhill, Glasgow.
1903. Roberts, Norcliffe, M.D., B.S.Durh. (Senior Assistant Medical Officer, Horton Mental Hospital, Epsom, Surrey); Horton County of London War Hospital, Epsom.
1887. Robertson, Geo. M., M.D., C.M., F.R.C.P.Edin., M.P.C., Physician-Superintendent, Royal Asylum, Morningside, Edinburgh.
1908. Robertson, George Dunlop, L.R.C.S.&P.Edin., Dipl. Psych., Assistant Medical Officer, District Asylum, Hartwood, Lanark.
1916. Robertson, Jane I., M.B., Ch.B.Glasg., Gartnavel Asylum, Glasgow.
1895. Robertson, William Ford, M.D., C.M.Edin., 60, Northumberland Street, Edinburgh.
1900. Robinson, Harry A., M.D., Ch.B.Vict., 140, Edge Lane, Liverpool.
1911. Robson, Capt. Hubert Alan Hirst, M.R.C.S., L.R.C.P.Lond., Punjaub Asylum, India.
1914. Rodger, Murdoch Mann, M.D., Ch.B.Glasg., The Rowans, Bothwell, Scotland.
1908. Rodgers, Frederick Millar, M.D., Ch.B.Vict., D.P.H. (Senior Medical Officer, County Asylum, Winwick, Lancs.); Lord Derby's War Hospital, Winwick.
1908. Rolleston, Charles Frank, B.A., M.B., Ch.B.Dub., Assistant Medical Officer, County of London Manor Mental Hospital, Epsom.
1895. Rolleston, Lancelot W., M.B., B.S.Durh. (Medical Superintendent, Middlesex County Asylum); Napsbury War Hospital, Napsbury, near St. Albans.
1888. Ross, Chisholm, M.D.Syd., M.B., C.M.Edin., 151, Macquarie Street, Sydney, New South Wales.
1913. Ross, Derind Maxwell, M.B., Ch.B.Edin., Morningside Asylum, Edinburgh.



1910. Ross, Donald, M.B., Ch.B.Edin., Argyll and Bute Asylum, Lochgilphead.  
 1905. Ross, Sheila Margaret, M.D., Ch.B.Edin., 83A, Friar Gate, Derby.  
 1899. Rotherham, Arthur, M.A., M.B., B.C.Cantab., Commissioner under Ment. Defec. Act, Board of Control, 66, Victoria Street, Westminster, London, S.W. 1.  
 1906. Rowan, Marriott Logan, B.A., M.D.R.U.I., Medical Superintendent, Derby County Asylum, Mickleover.  
 1883. Rowland, E. D., M.B., C.M.Edin., 71, Main Street, George Town, Demerara, British Guiana.  
 1902. Rows, Richard Gundry, M.D.Lond., M.R.C.S., L.R.C.P.Lond. (Pathologist, County Asylum, Lancaster), British Red Cross Military Hospital, Maghull, Liverpool.  
 1877. Russell, Arthur P., M.B., C.M., M.R.C.P.Edin., The Lawn, Lincoln.  
 1912. Russell, John Ivison, M.B., Ch.B.Glasg., Jeanfield, 18, Woodend Drive, Jordan Hill, Glasgow.  
 1915. Russell, William, M.B., Ch.B.Edin., Dip.Psych.Edin., D.T.M.Edin., Assistant Physician, Pretoria Mental Hospital, S. Africa.  
 1912. Rutherford, Cecil, M.B., B.Ch.Dubl. (Assistant Medical Officer, Holloway Sanatorium, Virginia Water, Surrey); No. 16 Standard Hospital, Mediterranean Expeditionary Force.  
 1907. Rutherford, Henry Richard Charles, F.R.C.S.I., L.R.C.P.I., D.P.H., St. Patrick's Hospital, James's St., Dublin.  
 1896. Rutherford, James Mair, M.B., C.M., F.R.C.P.Edin., M.P.C., Brislington House, Bristol.  
 1913. Ryan, Ernest Noel, B.A., M.D., B.Ch.Dub., 6th London Field Ambulance (T.).
1902. Sall, Ernest Frederick, M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Borough Asylum, Canterbury.  
 1908. Samuels, William Frederick, L.M.&L.S.Dubl., Medical Superintendent, Central Asylum, Tangong, Rambutan, Perak, Federated Malay States.  
 1894. Sankey, Edward H. O., M.A., M.B., B.C.Cantab., Resident Medical Licensee, Boreatton Park Licensed House, Baschurch, Salop.  
 Sankey, R. H. Heurtley, M.R.C.S.Eng., 3, Marston Ferry Road, Oxford.  
 1873. Savage, Sir Geo. H., M.D., F.R.C.P.Lond., 26, Devonshire Place, London, W. 1. (*Late Editor of Journal.*) (PRESIDENT, 1886.)  
 1906. Scalan, John J., L.R.C.P.&S.Edin., L.R.F.P.&S.Glasg., D.P.H. (1 Castle Court, Cornhill, London, E.C. 3); 5th London Field Ambulance, 47th (London) Division, British Expeditionary Force.  
 1896. Scott, James, M.B., C.M.Edin., 98, Baron's Court Road, West Kensington, London, W. 14.  
 1915. Scott, James McAlpine, M.D., Ch.B.Glasg., Junior Assistant Medical Officer, Stirling District Asylum, Larbert.  
 1889. Scowcroft, Walter, M.R.C.S., L.R.C.P.I., Medical Superintendent, Royal Lunatic Hospital, Cheadle, near Manchester.  
 1911. Scroope, Geoffrey, M.B., B.Ch.Dub., Assistant Medical Officer, Central Asylum, Dundrum.  
 1880. Seccombe, George S., M.R.C.S., L.R.C.P.Lond., c/o Messrs. H. S. King and Co., 65, Cornhill, London, E.C. 3.  
 1912. Sergeant, John Noel, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Newlands House, Tooting Bec Common, London, S.W. 17. (*Secretary South-Eastern Division since 1913.*)  
 1913. Shand, George Ernest, M.D., Ch.B.Aberdeen; (Senior Assistant Medical Officer, City Mental Hospital, Winson Green, Birmingham). *Temporary address*: 4, Odessa Road, Harlesden, London, N.W. 10. *Permanent address*: 307, Gilottt Road, Edgbaston, Birmingham.  
 1901. Shaw, B. Henry, M.B., B.Ch.R.U.I., Assistant Medical Officer, County Asylum, Stafford.  
 1909. Shaw, William Samuel J., M.B., B.Ch.R.U.I., Superintendent, North Veravola, Poona, India.  
 1905. Shaw, Charles John, M.D., Ch.B., F.R.C.P.E., Medical Superintendent, Royal Asylum, Montrose.

1915. Shaw, Hugh Kirkland, M.B., Ch.B.Edin., Assistant Medical Officer, Stirling District Asylum, Larbert.
1917. Shaw, John Custance, M.R.C.S.Eng., L.R.C.P.Lond., Medical Superintendent, West Ham Borough Asylum, Goodmayes, Essex.
1904. Shaw, Patrick, L.R.C.P.&S.Edin., Senior Medical Officer (Hospital for the Insane, Kew, Victoria, Australia); "Lingerwood," Wills Street, Kew, Victoria, Australia. *On active service.*
1909. Shepherd, George Ferguson, F.R.C.S., L.R.C.P.Irel., D.P.H., 9, Ogle Terrace, South Shields.
1900. Shera, John E. P., M.D.Brux., L.R.C.P.&S.Irel., Somerset County Asylum, Wells, Somerset.
1912. Sheridan, Gerald Brinsley, M.B., B.Ch.R.U.I., Assistant Medical Officer, Portrane Asylum, Donabate, Co. Dublin.
1914. Sherlock, Edward Burball, M.D., B.Sc., D.P.H.Lond., Medical Superintendent, Darenth Industrial Colony, Dartford.
1914. Shield, Hubert, M.B., B.S.Durh. (Assistant Medical Officer, Gateshead Borough Asylum, Stannington, Newcastle-on-Tyne); 1st Nottingham Field Ambulance, British Expeditionary Force, France.
1877. Shuttleworth, George E., B.A.Lond., M.D.Heidelb., M.R.C.S. and L.S.A. Lond., 25, New Cavendish Street, London, W. 1; 36, Lambolde Road, Hampstead, London, N.W. 3.
1901. Simpson, Alexander, M.A., M.D., C.M.Aber. (Medical Superintendent, County Asylum, Winwick, Newton-le-Willows, Lancashire); Lord Derby War Hospital, Warrington.
1905. Simpson, Edward Swan, M.D., Ch.B.Edin., East Riding Asylum, Beverley, Yorks.
1888. Sinclair, Eric, M.D., C.M.Glasg., Inspector-General of Insane, Richmond Terrace, Demain, Sydney, N.S.W.
1891. Skeen, James Humphry, M.B., Ch.M.Aber., M.P.C., Medical Superintendent, Fife and Kinross District Asylum, Cupar, N.B.
1900. Skinner, Ernest W., M.D., C.M.Edin., J.P., Mountsfield, Rye, Sussex.
1914. Slaney, Chas. Newnham, M.R.C.S., L.R.C.P.Lond., The Elms, Parkhurst, I.W.
1901. Slater, George N. O., M.D.Lond., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Essex County Asylum, Brentwood.
1914. Smith, Charles Kelman, M.B., Ch.B.Aberd., Assistant Medical Officer, Parkside Asylum, Macclesfield.
1910. Smith, Gayton Warwick, M.D.Lond., B.S.Durh., D.P.H.Cantab., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Middlesex County Asylum, Tooting, London, S.W. 17.
1905. Smith, George William, M.B., Ch.B.Edin. (Assistant Medical Officer, Holloway Sanatorium, Virginia Water, Surrey).
1907. Smith, Henry Watson, M.D., Ch.B.Aberd., Medical Superintendent, Lebanon Hospital for the Insane, Asfurujeh, near Beyrout, Syria.
1899. Smith, John G., M.D., C.M.Edin., Herts County Asylum, Hill End, St. Albans, Herts.
1885. Smith, R. Percy, M.D., B.S., F.R.C.P.Lond., M.P.C., 36, Queen Anne Street, Cavendish Square, London, W. 1. (*General Secretary*, 1896-7. *Chairman Educational Committee*, 1899-1903.) (PRESIDENT, 1904-5.)
1913. Smith, Thomas Cyril, M.B., B.Ch.Edin., County Asylum, Gloucester.
1911. Smith, Thomas Waddelow, F.R.C.S., L.R.C.P.Lond., M.P.C., Assistant Medical Officer, City Asylum, Mapperley Hill, Nottingham.
1884. Smith, W. Beattie, F.R.C.S.Edin., L.R.C.P.Edin., 4, Collins Street, Melbourne, Victoria.
1914. Smith, Walter H., B.A., M.D., B.Ch.Dub., Senior Assistant Medical Officer, County Asylum, Shrewsbury.
1899. Smyth, Walter S., M.B., B.Ch.R.U.I., Assistant Medical Officer, County Asylum, Antrim.
1913. Somerville, Henry, B.Sc., M.R.C.S., L.R.C.P.Lond., F.C.S., Harrold, Sharnbrook, Bedfordshire.

1885. Soutar, James Greig, M.B., C.M.Edin., M.P.C., Barnwood House, Gloucester. (PRESIDENT, 1912-13.)
1906. Spark, Percy Charles, M.R.C.S., L.R.C.P.Lond., Medical Superintendent, London County Asylum, Banstead, Surrey.
1875. Spence, J. Beveridge, M.D., M.C.Q.U.I., Medical Superintendent, Burntwood Asylum, near Lichfield. (*First Registrar*, 1892-1899; *Chairman Parliamentary Committee*, 1910-12.) (PRESIDENT, 1899-1900.)
1891. Stansfield, T. E. K., M.B., C.M.Edin., Medical Superintendent, London County Mental Hospital, Bexley, Kent.
1901. Starkey, William, M.B., B.Ch.R.U.I., Medical Superintendent, Borough Asylum, Blackadon, Ivybridge, S. Devon.
1907. Steele, Patrick, M.D., Ch.B., M.R.C.P.Edin., Assistant Medical Officer, District Asylum, Melrose.
1898. Steen, Robert H., M.D.Lond., M.R.C.P.Lond., Medical Superintendent, City of London Mental Hospital, Stone, Dartford. (*Hon. Sec. S.E. Division*, 1905-10; *Acting Gen. Sec. and Gen. Sec.* since 1915.)
1914. Stephens, Harold Freize, M.R.C.S.Lond., L.R.C.P.Eng., 9, Belmont Avenue, Palmer's Green, Middlesex.
1914. Stevenson, George Henderson, M.B., Ch.B.Edin., D.P.H.Lond., Joyce Green Hospital, Dartford, Kent.
1912. Stevenson, William Edward, M.B., B.S.Durh., Winnell Down Camp, Winchester.
1909. Steward, Sidney John, M.D., D.S.O., B.C.Cantab., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Langton Lodge, Farncombe, Surrey.
1915. Stewart, A. H. L., M.R.C.S., 72, Wimpole Street, London, W. 1.
1868. Stewart, James, B.A.Belf., F.R.C.P.Ed., L.R.C.S.I., "Donegal," 32, Kingsmead Road, Tulse Hill, London, S.W. 2.
1913. Stewart, Ronald, M.B., Ch.B.Glasg. (Gartloch Asylum, Gartcosh, Glasgow); No. 38 Hospital, Mediterranean Expeditionary Force.
1887. Stewart, Rothsay C., M.R.C.S.Eng., L.S.A.Lond., Medical Superintendent, County Asylum, Narborough, near Leicester.
1914. Stewart, Roy M., M.B., Ch.B.Edin. (Assistant Medical Officer, County Asylum, Prestwich); Mediterranean Expeditionary Force, c/o G.P.O., E.C. 1.
1905. Stilwell, Henry Francis, L.R.C.P.&S.E., Hayes Park, Hayes, Middlesex.
1899. Stilwell, Reginald J., M.R.C.S., L.R.C.P.Lond., Moorcroft House, Hillingdon, Middlesex.
1897. Stoddart, William Henry Butter, M.D., B.S., F.R.C.P.Lond., M.R.C.S.Eng., M.P.C., Harcourt House, Cavendish Square, London, W. 1. (*Hon. Sec. Educational Committee*, 1908-1912.)
1909. Stokes, Frederick Ernest, M.B., Ch.B.Glasg., D.P.H.Cantab. (Assistant Medical Officer, Borough Asylum, Portsmouth); 2/3 Wessex Field Ambulance.
1905. Strathearn, John, M.D., Ch.B.Glasg., F.R.C.S.E., 23, Magdalen Yard Road, Dundee.
1903. Stratton, Percy Haughton, M.R.C.S., L.R.C.P.Lond., 10, Hanover Square, London, W. 1.
1885. Street, C. T., M.R.C.S., L.R.C.P.Lond., Haydock Lodge, Ashton, Newton-le-Willows, Lancashire.
1909. Stuart, Frederick J., M.R.C.S., L.R.C.P.Lond. (Senior Assistant Medical Officer, Northampton County Asylum, Berrywood); War Hospital, Dunston, Northampton.
1900. Sturrock, James Prain, M.A.St.And., M.D., C.M.Edin., 25, Palmerston Place, Edinburgh.
1886. Suffern, Alex. C., M.D., M.Ch.R.U.I. (Medical Superintendent, Rubery Hill Asylum, near Bromsgrove, Worcestershire); 1st Birmingham War Hospital, Rubery Hill, Worcestershire.
1894. Sullivan, William C., M.D., B.Ch.R.U.I., Rampton Criminal Lunatic Asylum, Retford, Notts.
1918. Sutherland, Francis, M.B., Ch.B.Ed., Senior Assistant Physician, Royal Asylum, Aberdeen.



1910. Sutherland, Joseph Roderick, M.B., Ch.B.Glasg., M.R.C.S., L.R.C.P. Lond., D.P.H., County Sanatorium, Stonehouse, Lanarkshire.
1908. Swift, Eric W. D., M.B.Lond., Medical Superintendent, Government Asylum, Bloemfontein.
1908. Tattersall, John, M.D.Lond., M.R.C.S., M.R.C.P.Lond., Assistant Medical Officer, London County Asylum, Hanwell, London, W. 7.
1910. Taylor, Arthur Loudoun, B.Sc., M.B., Ch.B., M.R.C.P.Edin., 30, Hartington Place, Edinburgh.
1897. Taylor, Frederic Ryott Percival, M.D., B.S.Lond., M.R.C.S., L.R.C.P. Lond., Medical Superintendent, East Sussex Asylum, Hellingly.
1918. Thienpont, Rudolph, M.D., Temporary Assistant Medical Officer, Cane Hill Mental Hospital, Coulsdon, Surrey.
1908. Thomas, Joseph D., B.A., M.B., B.C.Cantab., Northwoods House, Winterbourne, Bristol.
1911. Thomas, William Rees, M.D., B.S.Lond., M.R.C.S., M.R.C.P.Lond., M.P.C. (Mossdale, Maghull, near Liverpool); British Red Cross War Hospital, Maghull, near Liverpool.
1880. Thomson, David G., M.D., C.M.Edin. (Medical Superintendent, County Asylum, Thorpe, Norfolk); Norfolk War Hospital, Thorpe, Norwich. (PRESIDENT, 1914-18.)
1903. Thomson, Herbert Campbell, M.D., F.R.C.P.Lond., Assist. Physician Middlesex Hospital, 34, Queen Anne Street, London, W. 1.
1905. Tidbury, Robert, M.D., M.Ch. R.U.I., Heathlands, Foxhall Road, Ipswich.
1901. Tighe, John V. G. B., M.B., B.Ch.R.U.I., Medical Superintendent, Gateshead Mental Hospital, Stannington, Northumberland.
1914. Tisdall, C. J., M.B., Ch.B., Crichton Royal Institution, Dumfries.
1903. Topham, J. Arthur, B.A.Cantab., M.R.C.S., L.R.C.P.Lond., County Asylum, Chartham, Kent.
1896. Townsend, Arthur A. D., M.D., B.Ch.Birm., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Hospital for Insane, Barnwood House, Gloucester.
1904. Treadwell, Oliver Ferreira Naylor, M.R.C.S.Eng., L.S.A.Lond., 90, St. George's Square, London, S.W. 1.
1903. Tredgold, Alfred F., M.R.C.S., L.R.C.P.Lond. (6, Dapdune Crescent, Guildford, Surrey).
1908. Tuach-MacKenzie, William, M.D., Ch.B.Aberd., Medical Superintendent, Royal and District Asylums, Dundee.
1881. Tuke, Charles Molesworth, M.R.C.S.Eng., Chiswick House, Chiswick.
1888. Tuke, John Batty, M.D., C.M., F.R.C.P.Edin., Resident Physician, New Saughton Hall, Polton, Midlothian.
1915. Tulloch, William John, M.D.St. Andrews, Director Western Asylums Research Institute, 10, Claythorn Road, Glasgow.
1906. Turnbull, Peter Mortimer, M.B., B.Ch.Aberd., Tooting Bec Asylum, Tooting, London, S.W. 17.
1909. Turnbull, Robert Cyril, M.D.Lond., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Essex County Asylum, Colchester.
1889. Turner, Alfred, M.D., C.M.Edin., Plympton House, Plympton, S. Devon.
1906. Turner, Frank Douglas, M.B.Lond., M.R.C.S., L.R.C.P.Lond., Medical Officer, Royal Eastern Counties Institution, Colchester.
1890. Turner, John, M.B., C.M.Aberd., Medical Superintendent, Essex County Asylum, Brentwood.
1917. Vevers, Oswald Henry, M.R.C.S., L.R.C.P.Lond., Acting Medical Superintendent, Laverstock House, Salisbury.
1904. Vincent, George A., M.B., B.Ch.Edin., Assistant Medical Superintendent, St. Ann's Asylum, Port of Spain, Trinidad, B.W.I.
1894. Vincent, William James N., M.B., B.S.Durh., M.R.C.S., L.R.C.P.Lond. (Medical Superintendent, Wadsley Asylum, near Sheffield); Wharnccliffe War Hospital, Sheffield.
1914. Vining, Charles Wilfred, M.D., B.S.Lond., M.R.C.P.Lond., D.P.H., M.P.C., Assistant Physician, Leeds General Infirmary, 40, Park Square, Leeds.

1913. Walford, Harold R. S., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Kent County Asylum, Barming Heath, Maidstone.
1914. Walker, Robert Clive, M.B., Ch.B.Edin., West Riding Asylum, Menston, near Leeds.
1908. Wallace, John Andrew Leslie, M.D., Ch.B.Edin., M.P.C., Mental Hospital, Callan Park, Sydney, N.S.W.
1912. Wallace, Vivian, L.R.C.P. & S.I., Assistant Medical Officer, Mullingar District Asylum, Mullingar.
1889. Warnock, John, C.M.G., M.D., C.M., B.Sc.Edin., Medical Superintendent, Abbasiyeh Asylum, nr. Cairo, Egypt.
1895. Waterston, Jane Elizabeth, M.D.Bru., L.R.C.P.I., L.R.C.S.Edin., M.P.C., 85, Parliament Street, Box 78, Cape Town, South Africa.
1902. Watson, Frederick, M.B., C.M.Edin., Elm Lodge, Clay Hill, Enfield.
1891. Watson, George A., M.B., C.M.Edin., M.P.C., Lyons House, Rainhill, Liverpool.
1908. Watson, H. Ferguson, M.D., Ch.B.Glas., L.R.C.P.&S.E., L.R.F.P.&S.Glas., D.P.H., Northcote, Edinburgh Road, Perth.
1911. Webber, Leonard Mortis, M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Netherne, Merstham, Surrey.
1911. White, Edward Barton C., M.R.C.S., L.R.C.P.Lond. (Senior Assistant Medical Officer, Cardiff City Mental Hospital, Whitchurch); Welsh Metropolitan War Hospital, Whitchurch.
1884. White, Ernest William, M.B.Lond., M.R.C.P.Lond., Betley House, nr. Shrewsbury. (*Hon. Sec. South-Eastern Division, 1897-1900.*) (*Chairman Parliamentary Committee, 1904-7.*) (*PRESIDENT 1903-4.*)
1905. Whittington, Richard, M.A., M.D.Oxon., M.R.C.S., L.R.C.P.Lond., (Downford, Montpelier Road, Brighton); 2nd East General Hospital, Brighton.
1889. Whitwell, James Richard, M.B., C.M.Edin., Medical Superintendent, Suffolk County Asylum (St. Audry's Hospital), Melton, Suffolk.
1903. Wigan, Charles Arthur, M.D.Durh., M.R.C.S.Eng., L.S.A.Lond., Deepdene, Portishead, Somerset.
1883. Wiglesworth, Joseph, M.D., F.R.C.P.Lond., Springfield House, Winscombe, Somerset. (*PRESIDENT, 1902-3.*)
1913. Wilkins, William Douglas, M.B., Ch.B.Vict., M.R.C.S., L.R.C.P.Lond., County Mental Hospital, Cheddleton, Leek, Staffs.
1900. Wilkinson, H. B., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer, Plymouth Borough Asylum, Blackadon, Ivybridge, South Devon.
1887. Will, John Kennedy, M.A., M.D., C.M.Aberd., M.P.C., Bethnal House, Cambridge Road, London, N.E.1.
1914. Williams, Charles, L.R.C.P. & S.Edin., L.S.A.Lond., Assistant Medical Officer, The Warneford, Oxford.
1907. Williams, Charles E. C., M.A., M.D., B.Ch.Dubl.; Greystones, Carnford Cliffs, Bournemouth; No. 12 General Hospital, British Expeditionary Force, France.
1905. Williams, David John, M.R.C.S., L.R.C.P.Lond., Medical Superintendent, The Asylum, Kingston, Jamaica.
1915. Williams, Gwilym Ambrose, L.R.C.P.Lond., M.R.C.S.Eng. (Pathologist and Assistant Medical Officer, East Sussex County Asylum, Hellingly); 27th General Hospital, Mediterranean Expeditionary Force.
1916. Wilson, Marguerite, M.B., Ch.B.Glasg., c/o Messrs. Wilson and Baird, 372, Scotland Street, Glasgow.
1912. Wilson, Samuel Alexander Kinnier, M.A., M.D., B.Sc.Edin., F.R.C.P.Lond., Registrar, National Hospital, Queen's Square, 14, Harley Street, London, W.1.
1897. Winder, W. H., M.R.C.S., L.R.C.P.Lond., D.P.H.Cantab., Deputy Medical Officer, H.M. Borstal Institution, Borstal, Kent.
1899. Wolseley-Lewis, Herbert, M.D.Bru., F.R.C.S.Eng., L.R.C.P.Lond., Medical Superintendent, Kent County Asylum, Barming Heath, Maidstone. (*Secretary Parliamentary Committee, 1907-12. Chairman of same since 1912.*)

1869. Wood, T. Outterson, M.D.Durh., M.R.C.P.Lond., F.R.C.P., F.R.C.S. Edin., 7, Abbey Crescent, Torquay. (PRESIDENT, 1905-6.)
1912. Woods, James Cowan, M.D., B.S.Lond., M.R.C.S., L.R.C.P.Lond., 10, Palace Green, Kensington, London, W. 8.
1885. Woods, J. F., M.D.Durh., M.R.C.S.Eng., 7, Harley Street, Cavendish Square, London, W. 1.
1912. Wootton, John Charles, M.R.C.S.Eng., L.R.C.P.Lond., Haydock Lodge, Newton-le-Willows, Lancs.
1900. Worth, Reginald, M.B., B.S.Durh., M.R.C.S., L.R.C.P.Lond., Medical Superintendent, Middlesex Asylum, Tooting, London, S.W. 17.
1917. Wright, Maurice Beresford, M.D., C.M. (118, Harley Street, London, W. 1); 10, Palace Green, Kensington, London, W. 8.
1862. Yellowlees, David, LL.D.Glas., M.D.Edin., F.R.F.P.&S.Glasg., 6, Albert Gate, Dowan Hill, Glasgow. (PRESIDENT, 1890.)
1914. Yellowlees, Henry, M.B., Ch.B.Glas., 6, Albert Gate Dowan Hill, Glasgow; 26th British General Hospital, British Expeditionary Force.
1910. Younger, Edward George, M.D.Bruce., M.R.C.P., M.R.C.S., L.S.A.Lond., D.P.H., Physician to the Finsbury Dispensary, 2, Mecklenburgh Square, London, W.C. 1.

ORDINARY MEMBERS	...	...	...	...	...	626
HONORARY MEMBERS	...	...	...	...	...	32
CORRESPONDING MEMBERS	...	...	...	...	...	17
Total	...	...	...	...	...	675

*Members are particularly requested to send changes of address, etc., to The General Secretary, 11, Chandos Street, Cavendish Square, London, W. 1, and in duplicate to the Printers of the Journal, Messrs. Adlard & Son & West Newman, Ltd., 23, Bartholomew Close, London, E.C. 1.*

## OBITUARY.

### *Honorary Members.*

1887. Chapin, John B., M.D., Canandaigua, N.Y., U.S.A.
1912. Maudsley, Henry, LL.D.Edin. (Hon.), M.D.Lond., F.R.C.P.Lond., Heathbourne, Bushey Heath, Herts. (PRESIDENT, 1871.) (Formerly Editor, *Journal of Mental Science*.)

### *Corresponding Member.*

1890. Régis, Dr. E., 54, Rue Huguerie, Bordeaux.

### *Members.*

1894. Baily, Percy J., M.B., C.M.Edin., 24, Barrack Road, Bexhill-on-Sea.
1914. Gettings, Harold Salter, L.R.C.P. & S.Edin., L.R.F.P.&S.G., D.P.H.Birm., Inoculation Dept., St. Mary's Hospital, Paddington.
1915. Griffith, Alfred Hume, M.D.Edin., D.P.H.Camb., Medical Superintendent, Lingfield Epileptic School Colony, The Homestead, Lingfield, Surrey.
1906. Herbert, Thomas, M.R.C.S., L.R.C.P.Lond., York City Asylum, Fulford, York.
1903. Logan, Thomas Stratford, L.R.C.P.&S.Edin., L.R.F.P.&S.Glas., D.P.H., Stone Asylum, Aylesbury, Bucks.
1914. O'Flynn, Dominick Thomas, L.R.C.P. & S.I., Assistant Medical Officer, London County Asylum, Hanwell, Middlesex.
1875. Philipson, Sir George Hare, M.A., M.D.Cantab., D.C.L., LL.D., F.R.C.P. Lond., 7, Eldon Square, Newcastle-on-Tyne.

1887. Reid, William, M.D., C.M.Aberd., Physician Superintendent, Royal Asylum, Aberdeen.
1882. Seward, William J., M.B.Lond., M.R.C.S.Eng., 15, Chandos Avenue, Oakleigh Park, London, N. 11.
1913. Spensley, Frank Oswald, M.R.C.S., L.R.C.P.Lond., Senior Medical Officer, Darenth Asylum, Dartford, Kent.
1875. Winslow, Henry Forbes, M.D.Lond., M.R.C.P.Lond., M.R.C.S.Eng., 164, Marine Parade, Brighton.

THE  
JOURNAL OF MENTAL SCIENCE

[Published by Authority of the Medico-Psychological Association  
of Great Britain and Ireland.]

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No. 268 [NEW SERIES  
No. 232.] JANUARY, 1919. VOL. LXV.

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Part I.—Original Articles.

*Presidential Address.*<sup>(1)</sup> By JAMES V. ANGLIN, M.D., Medical Superintendent, the Provincial Hospital, St. John, New Brunswick.

[THE following address has reached us through the kindness of Dr. Brush, Managing Editor of the American *Journal of Insanity*.

The American Medico-Psychological Association includes members from both the United States and from Canada, and Dr. Anglin's address is an indication of the cordial feeling which exists between the members of the specialty in the old Dominion and in the great Republic of the West.

That Dr. Anglin is worthy of the honour no one who reads the address can possibly doubt, which in literary vigour and freshness, patriotic spirit and cheery optimism it would be difficult to match. Of Dr. Anglin Dr. Brush writes :

"Dr. Anglin is a most loyal subject of Great Britain. He lost a son last spring, who died leading his men in a charge at Vimy Ridge ; another son has been invalided home a permanent cripple from gunshot wounds received in the trenches ; a third son is now in the ranks in France with the Canadian forces, and a fourth is just getting prepared to leave for overseas' military service.

"The address reflects the spirit which has animated the whole of Canada, with the exception of some of the French-Canadians in the province of Quebec, who, curiously, are not interested in the fate of the land of their French ancestors.

"I make the following quotation from a letter received from Dr. Anglin when sending me proof-slips for the *Journal of Insanity* : ' It (referring to the address) was put together under very trying circumstances. There were uppermost the anxieties about my boys. Then, I had to work on a military tribunal for months past. Help was so scarce I was worried

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to death, and scarcity of coal through an unusually severe winter deprived me of sleep. Everything seemed to militate against the preparation of an address.'

"The address awoke an enthusiastic response from the Association, and will, it seems to me, be appreciated on your side of the ocean."

With this anticipation on the part of Dr. Brush we cordially agree.  
—EDS., *J.M.S.*]

To this, the seventy-fourth annual meeting of our Association, opened so auspiciously, it is my privilege to welcome you officially.

It was with trepidation that preparations for it were proceeded with in this year of stress, but its carrying on will be justified if our coming together enlarges the common store of useful knowledge; increases our mutual understanding; helps to sweep away obstacles to the advance of the healing art, and quickens us to do our bit in freedom's cause, whose battle-line reaches to our homes, our gardens, and our pockets.

Last year at the closing of the meeting, I took opportunity to thank the members there for selecting me for the presidency of this venerable body, and I now repeat how sincere is my appreciation of this distinction. It is most gratifying to have bestowed on one your best gift, as it expresses what all men covet earnestly—the goodwill of one's associates. And yet there wells up in mind the thought that when in the sunny south I was placed in line for the chair I may now occupy, it was—in part at least—because I was a citizen of no mean country, and the majority of you, holding allegiance to another, sought in some measure to show your younger brother of the north that your heart was with him when he rushed into the fray to fight for the liberty championed by Great Britain, and thrilled that fond mother who had thrown her protecting arms about him from his tenderest years, without other return than his loyalty and love.

Fifty years ago Canada had her first Dominion Day, when from the position of a group of provinces lying on the banks of a magnificent waterway she stepped into self-conscious nationhood, embracing a territory which now stretches from sea to sea, and from the river, St. Lawrence, to the end of the earth. Britain's tenure of Canada depends neither on the strength of her battalions nor on the might of her fleets. Within her borders there has not been stationed since my earliest recollection a single soldier nor a single cannon over which Britain claimed control. Yet her influence in her great colony has grown more and more powerful. The Canadian people are animated by the same sentiments of loyalty as are found in the isles of their fathers, and British interests are as secure in their keeping as in the very core of the Empire.

I need not recount Canada's contribution to the present conflict.



Everywhere in this country you have been generous in the extreme in expressing admiration of the spirit of the Dominion.

Germany did not believe that the lion would be able to obtain effective assistance from its whelps in the event of a European war. This opinion must have been derived from the Victorian era, when knowledge of the colonies was vague.

It is only within recent years that British statesmen have shown any real understanding of their dominions beyond the seas. There was a day when one can imagine their welcoming the news that every colony of the Empire had issued a declaration of independence, fashioned on the model of that with which Washington confounded the politicians who surrounded the King.

Canada got on the British map during the Boer War, appealingly and permanently. Over in England they sat up and took notice then, though many who are fighting with us now were not quite sure we were doing the right or chivalrous thing. But most people outside of Germany and Britain did not realise that the Kaiser's cable to Kruger was the formal shying of his helmet into the ring, and the existence of the British Empire was at stake in South Africa. In the darkest period of the Boer War Canada had sprung to arms, which should have been an augury to Germany of what the colonies would do when their mother was in trouble.

It is a part of our national creed that what the nineteenth century was to this great neighbouring republic the twentieth will be to my country. Canada's soil is destined to support teeming millions. With boundless acres, enriched by wastefulness while the lone Indian scoured the plains, capable of providing the world with the finest of the wheat, with mineral stores of wonders untold, with unrivalled natural forces and virgin forests, with a stern yet invigorating climate, one would indeed be bold who would picture the meridian splendour of the nation which possesses such an heritage.

The most important purpose of such an Association as ours is the mutual improvement of its members by advancement in knowledge. No class stands in greater need of getting together frequently than do men of our profession. We are called on to decide complicated problems involving the well-being—yea, the very lives of our fellows. The experience of the greatest is limited. It is easy to stray from the narrow path. There is no corrective equal to discussions with others. In this matter our Association has accomplished much. We have a journal to link us together through the year. It gives an account of our meetings, which is a boon for those who cannot attend. Experimenters through this medium can convey information as to their hopes, aims, and accomplishments directly, without filtering through foreign publications. That man deceives himself, however, who fancies he can

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derive the same benefit from a perusal of the journal as he would from coming to our meetings. He misses the second object to be attained in a society like this—the binding together of its members by means of social intercourse.

Ample time should be allowed for interchange of opinion over the tea-cups, or any place as congenial. While there is room for reminiscences not purely scientific, mental stimulus is to be derived from contact one with another, quietly discussing problems about our life-work.

“Our discords, quenched by meeting harmonies,  
Die in the large and charitable air.”

The present time is for all of us one of deepest anxiety, with a great sense of unrest. The angry clouds of war have hung heavily over us for nearly four years, and show no signs of lifting. Many friends are overseas, to mitigate suffering, liable and ready to give their lives, if need be, in behalf of country, liberty, and our ideals of honour, truth, and justice. Some dearer to us than tongue can tell are in the fighting ranks, in jeopardy every hour.

With such distraction it was impossible to focus the mind on such an address as you have usually had from the long line of my forerunners, even were such timely, and I capable of keeping to the beaten path. The constitution says your President shall prepare an inaugural. He is not to come here, open his mouth, and expect the Lord to fill it. In an effort to obey I shall occupy further time while you become acclimated to this lake region with an endeavour to discover some silver lining to the leaden clouds on which Mars is riding so recklessly. For myself, I was born beside these waters after they had laved Chicago, and so am quite at home. The horrors of war are so constantly present that there may be some consolation in looking for another side.

I remember how in the first days of the war we stood aghast and said it could not endure more than a few weeks; how David Starr Jordan proved conclusively, we thought, that the bankers would never permit a world war to begin; how Samuel Gompers said that Labour would prevent the rupture of international peace; and how that brilliant wielder of the pen, Goldwin Smith, had declared that Canadians would never face a bayonet for England's sake. We have lived to see how far astray were such surmises. The greatest conflict in history not only began but has extended over weary years. Labouring men, who had pledged their word to protect their alien brothers, flew to the colours of the greatest autocrat of all time, and the best of Canadian youth are over there, where they have proved themselves of such stuff that no troops have put greater fear into the hearts of the foe. They have shown invaluable initiative, innate to the new world, and your boys will do the same.

So, though the future may not bear one out in taking the optimist's

view-point, no harm can follow "reaching a hand through time to catch the far-off interest of tears."

Every evil thing is followed by some good, and every achievement of good only uncovers some further ill for men to combat. Early in the war, in nearly all the belligerent countries, there was a sudden decrease of crime due to the absorption of many lawbreakers into the armies and fewer idle hands for Satan to get busy with. A few months later, however, juvenile crime increased from lack of parental control, the fathers having gone to war, the mothers to work.

Likewise, war found work for everybody. Thousands of families who were never far from the starvation line now earn wages they never dreamed they could command. That is a good thing, but it, too, has its demoralising side. Money thus unexpectedly possessed threw men and women off their moral balance, and the saloon has flourished.

It is in these contradictory elements in our progress that ammunition is found for optimists and pessimists. The pessimists claim that the evil counterbalances the good. The optimists take the opposite view, and history seems to favour the latter.

Medicine itself is likely to gain little from the experience of war. It has taught the surgeons much about the proper application of Listerian principles; physicians, the efficacy of inoculations against diseases which formerly decimated armies; alienists, the effects of shell-shock. But such advances in knowledge, valuable as they are in themselves, have comparatively little application to ordinary life. The practical humanity of the medical officers, shown in so many ways, is indeed a relief to a contest in which angry nations use every means of destruction to exterminate each other. But the blast of war that blows on our ears makes the still small voice of science inaudible.

Some comfort comes from learning that there is no evidence, in Great Britain at least, that since the outbreak of the war the amount of insanity has increased. There has actually been a decrease in hospital admissions, due mainly to the absence of so many men in the Army, who are dealt with by the military if they become insane. Among women, the higher wages earned, and the separation allowances regularly received, have relieved domestic uncertainties. Many who had nothing to do previous to the war have forgotten self by throwing their energies into active work for others. Rich and poor alike are now busy all the time. The result is a vast improvement in the nation's mental stability. People whose lives were empty are interested from morning till night. Work is the surest consolation for the grievous sorrow of war.

Even among the soldiers mental disorders have not been as prevalent as expected. The French conclude that with a few exceptions, in which a pre-existent organic taint was always to be found, the war has

not been productive of insanity. It were well, quoth the observer, if the opposite could be said, namely, that insanity has not produced the war. What was chiefly feared was mental disorder among men worn out by the fatigue of the campaign, but such cases have been rare. The circumstances of service in the field react on the mind in so many ways and so differently from the influences of peace that new forms of mental trouble may result.

The experience of the war is certain to lead to better lunacy laws. There has long been complaint that mental disorders have been regarded on a different basis from physical. Though in no department of medicine is the need greater for the earliest treatment, yet the tendency of existing laws is to cause remedial treatment to be postponed. The trouble arises from the fact that the laws governing these matters were framed by lawyers who are concerned in arranging how people are to be protected. But public health asks how mental sufferers are to be best treated so that they may be cured. The lawyers' viewpoint, though important, has been allowed to outweigh all others. The war has made it necessary to deal with the problem in a fresh, untrammelled way. Hitherto the law has hindered early treatment in many cases by making certification necessary for admission to an institution, by inflicting the stigma of pauperism, and by branding the recent case with insanity with all the disastrous consequences that flow therefrom, unjust though they be. The Army has brushed these difficulties aside. Numerous cases of recent mental disturbance among the soldiers have been dealt with in special hospitals without being certified insane in the usual way. Out of nearly 4,000 such cases among the British troops less than 200 had to be transferred to an insane institution. The soldiers suffer from the stigma neither of insanity nor of pauperism, and there is no obstacle to the earliest and best treatment. A civilian should have the same advantages when a mental breakdown threatens. There is no essential difference between the case of the soldier who becomes insane in the defence of his country, and that of a woman who suffers from mental symptoms brought on by producing her country's defenders.

The maxim that medical science knows no national boundaries has been rudely shaken by the war. The Fatherland has been preparing for isolation from the medical world without its confines. Just as, years ago, the Kaiser laid his ban on French words in table menus, so, as early as 1914, German scientists embarked on a campaign against all words which had been borrowed from an enemy country. A purely German medical nomenclature was the end in view. The rest of the world need not grieve much if they show their puerile hate in this way. It will only help to stop the tendency to Pan-Germanism in medicine which has for some years past been gaining headway.



The Germans excel all other nations in their genius for advertising themselves. They have proved true the French proverb that one is given the standing he claims. On a slender basis of achievement they have contrived to impress themselves as the most scientific nation. Never was there greater imposture. They display the same cleverness in foisting on a gullible world their scientific achievements as their shoddy commercial wares. The two are of much the same value, made for show rather than endurance—in short, made in Germany.

While they were preparing men and munitions for their intended onslaught for world dominion, they were spending millions of dollars to win the admiration of both the working classes and the intellectuals of other nations, extolling the superior conditions of the Fatherland, picturing it a paradise, with model homes, short hours and high wages. This was but a cloak for the sinister plans of Prussian autocracy. But how great has been the disillusionment! The facts are its working classes laboured longer hours than in any other country and for starvation wages, the women and children toiled like beasts of burden in most strenuous trades, sweat-shops abounded, many suffered from lack of fuel and food, farmers were oppressed with a rigid caste system so arranged that a peasant child could never become other than a peasant. Instead of the villas embowered with flowers, the general mass of workers lived in barrack tenements, gloomy and foul, lacking baths and heat, but with gaudy exteriors as camouflage.

In the earliest months of the war it was pointed out that there are tendencies in the evolution of medicine as a pure science as it is developed in Germany which are contributing to the increase of charlatanism of which we should be warned. A medical school has two duties—one to medical science, the other to the public. The latter function is the greater, for out of every graduating class 90 *per cent.* are practitioners and less than 10 *per cent.* are scientists. The conditions in Germany are reversed. There, there were ninety physicians dawdling with science to every ten in practice. Of these 90, fully 75 *per cent.* were wasting their time. In Germany the scientific side is over-done, and they have little to show for it all, while the human side is neglected. Even in their new institutions, splendid as they are in a material sense, it is easy to be seen that the improved conditions were not for the comfort of the patients.

Out of this war some modicum of good may come if it leads to a revision of the exaggerated estimate that has prevailed in English-speaking countries of the achievements of the Germans in science. We had apparently forgotten the race that had given the world Newton, Faraday, Stephenson, Lister, Hunter, Jenner, Fulton, Morse, Bell, Edison, and others of equal worth. German scientists wait till a Pasteur has made the great discovery, on which it is easy for her



trained men to work. She shirks getting for herself a child through the gates of sacrifice and pain ; but steals a babe, and as it grows bigger under her care, boasts herself as more than equal to the mother who bore it. Realising her mental sterility, drunk with self-adoration, she makes insane war on the nations who still have the power of creative thought.

Alienists have been infatuated with German pseudo-discoveries. Novelty of terminology has been taken for originality of thought, and their works on insanity have been accorded undue authority. We ignored the substance in our own and the Motherland, and chased the mirage on the Continent.

Since the German army was successful in 1870, it has since been idolised, and the admiration bestowed on it has extended, so that in spite of the fact that the Germans themselves have gone to other countries for their ideas, we have cultivated a superstition of German pre-eminence in everything, but especially in science. There might be some excuse for this if they had made any discoveries comparable with those of the circulation of the blood, of vaccination, of asepsis—all made by men who speak our language ; or if German names were identified with important lesions or diseases as are those of Colles, Pott, Bright, Addison, Hughlings Jackson, Hutchinson, Argyll-Robertson, and others.

But it is especially in mental science that the reputation of the Germans is most exalted and is least deserved. For every philosopher of the first rank that Germany has produced, the English can show at least three. And in psychiatry, while we have classical writings in the English tongue, and men of our own gifted with clinical insight, we need seek no foreign guides, and can afford to let the abounding nonsense of Teutonic origin perish from neglect of cultivation.

The Germans are shelling Paris from their Gothas and their new gun. Murdering innocents, to create a panic in the heart of France ! With what effect ? The French army cries the louder, "They shall not pass" ; Paris glows with pride to be sharing the soldiers' dangers, and increases its output of war material ; and the American army sees why it is in France, and is filled with righteous hatred. Panic nowhere. Vengeance everywhere. What does the Hun know of psychology ? His most stupid, thick-witted performance was his brutal defiance of the United States with its wealth, resources, and energy. That revealed a mental condition both grotesque and pitiable.

After the war a centre of medical activity will be found on this side the Atlantic, and those who have watched the progress medical science has made in the United States will have no misgivings as to your qualifications for leadership. If we learn to know ourselves, great good will come out of this war.

Since 1914 there has been an awakening of the public conscience regarding health. An impetus has been given by the wonderful results of sanitation in the armies. In this we are interested because bodily disorder often foreruns mental, and many cases we treat are due to an infectious disease usually avoidable. Long ago Disraeli declared that public health is the foundation on which rests the happiness of the people and the strength of the nation. Statesmen generally are only now recognising that not only is the well-being of many millions of workers involved, but that the development of a country is checked if due attention is not given to the many problems associated with the maintenance of health.

In my home province this spring the Government has created a health department to give at least as much attention to human beings as it has done to domestic animals or the moose that attracts sportsmen to the wilderness. The more grave the situation in France becomes, the more vigorously should we strive to shield those who can assist in greater protection from preventable disease and lessened efficiency. The war has impressed us with the fact that the childhood of the nation is the second great line of defence, and every child must be saved not alone for its own sake or its parents, but for the continuance of the nation.

This war has shown us the value of developing the bodies of our young people. Wherever soldiers have been in the making there has been demonstrated what a change military training brings about in the recruits, converting youths of poor physique into erect, strapping, ruddy athletes. It is hard to realise they are the same human material, but for the first time in the lives of most of them they learned how to live. When compelled to endure hardships such as they never knew before, or lie in hospital recovering from wounds, the fitness secured by training is a decided factor in their favour. When the cruel war is over and welcome peace has stilled the stirring drum, shall the call for this physical fitness be no longer made? The need of it will not pass away. The demands of peace make it necessary that every youth be made as perfect as possible. And this applies equally to girls. The country which would produce a hardy race must have strong women as well as strong men.

Nationally, we had almost completely ignored the cultivation of the body. We make it compulsory for every child to submit to years at school for the sake of intellectual training. But its physical development has been left largely to chance and nature, and then when we call for soldiers we find a third of our youth unfit. It must be the State's business to attempt in every possible way to develop the physical life of our young people. Even if it meant the taking of a whole year for necessary training it would be a national boon, adding as it would

five or ten years to the life of the individual. The time for trusting to luck and letting things slide has surely passed. Benjamin Franklin said wars are not paid for in war time. The bill comes later. This is the sad truth, but the bill will be settled the sooner if we make the most of the rising race.

The war will hasten some scheme to provide all who need it with medical care. Often among the working classes disease leads to distress, and distress to disease, and charity in some form has been obliged to assist in destroying this vicious circle. Free hospitals have arisen, but this condition is not ideal, yet the man with meagre income must accept this charity. A better plan appears to be that of an insurance under which all wage-earners are compelled while well to accumulate a reserve which will defray part, at least, of the expense during periods of disability. Some such plan has just been pressed on the British to provide in case of illness or injury adequate care for all persons whose income is less than \$800 a year. Nine-tenths of the general practitioners in the British Isles have entered into the scheme.

On this Continent little attention has been given to a measure of this kind, but it seems probable that, whether medical men like it or not, a similar one will become law on this side of the Atlantic.

The war has brought about a curtailment in the abuse of alcoholic drinks. For some years past there has been a revolution going on in regard to intoxicants. The world-wide attack on liquor at the outbreak of the war was simply the crystallisation of an antagonistic sentiment which had been slowly forming, based on scientific evidence of the physiological and social effects of alcohol drinking.

There is no reason to suppose that the great temperance wave is a passing thing which will ebb when the excitement of the war is over. Unless all signs fail, it represents a permanent gain, whose far-reaching benefits members of this Association will be the first to appreciate. It is not the moral reformers who have brought prohibition to pass. There is now a solid body of educated sentiment behind the law. Business corporations are roused against the liquor traffic as they certainly were not twenty-five years ago, because they now recognise that whiskey and efficiency make a poor team. The world has travelled a long way since that first teetotaler applied for life insurance, and was charged an extra premium because total abstinence was so dangerous to health.

Social standards even in England, which still retains a bad pre-eminence in drunkenness, have marvellously changed since the days of Charles Dickens, who was quite unconscious that intemperance was anything more than an amiable weakness of generous and convivial hearts.

We are abolishing the bar. We still have the bottle. The quack-me dicinevendor is busier than ever. Money is plenty and he wants some of it. He uses mental suggestion and interests us. He is a specialist in distortion who probes into the ordinary sensations of healthy people and perverts them into symptoms. Every bill-board, newspaper, fence-rail, barn and rock thrusts out a suggestion of sickness as never before. The only vulnerable point to attack the vicious traffic is the advertising. If governments forbid that as they should, the next generation will be healthier and richer. If we are going to let imagination play, let us exercise it on suggestions and symptoms of health.

The world is moving rapidly in these days, and to women is being granted their rightful place. They are being given the ballot, not as a reward for what they had done in the war, but because they possessed the patriotism and the intelligence which entitle them to share in the conduct of public affairs.

We have been struck by the readiness with which our boys have responded to the country's call, and have admired their cheerfulness, but more impressive has been the heroism of the mothers, the wives, the sweethearts, and the sisters, who have sent forth the best we breed without a murmur. Theirs is the harder task to go quietly on with the daily routine while the heart is in France with the boys they love. While many talented ones have been prominent in public service, behind them lies a great army of women who are not known outside of their own small circle, and who are yet the nation's richest possession, its most sacred trust, who make life attractive, and freedom possible and worth while. We would never have had such valiant armies in France if it had not been for the brave women at home. The advent of women into political life means purer government, and the coming of long overdue reforms in the laws of the land.

Even our religion will be a better brand because of the war. Creeds count for little over there, and will never again divide men as they have done. Less and less emphasis is put on the sweet by-and-bye, and men's thoughts are turning to the service of their fellows here and now. They are recognising the practical unity of religion, and the square deal all round.

And so it will come to pass,

"That mind and soul, according well  
May make one music as before,  
But vaster."

The war is teaching us the value of thrift—that exceedingly useful virtue which most men practise only when they must. But unpopular as it has been, stern national necessity is now helping to restore it to its rightful place. On this continent we have not as yet gone far in this direction.



But in the Motherland there is another story. For over two years not a single new pleasure auto has been manufactured. Big social functions are not merely bad form—they have ceased altogether.

The traffic in luxuries in certain cases has been entirely wiped out. Everybody is wearing old clothes and saving the wool for the boys in the trenches, and saving the food that the Army may be properly fed. England is practising economy such as she never did before, and the strange thing is that apparently business is better than it was in the days of more luxurious living. One reason for this condition is undoubtedly the fact that everybody is working. The scale of living for the rich has been lowered, but the scale of living for the poor has been raised. This is probably a help to both classes. The pinch really comes, however, on the middle classes, whose salaries have not increased, but whose expenses have gone up by leaps and bounds. And yet there is no grumbling. The men who grumbled at everything in pre-war times are now silent when they have really something to grumble about. England in prosperity may sometimes be hard to put up with, but England in adversity is magnificent.

The war has done much for us if it has done nothing more than to reveal men to us. Before the war we judged them by their petty virtues or petty faults, and we thought we judged correctly ; but now we see that under it all lay a capacity and a willingness for self-denial and cheerful self-sacrifice that we had never suspected. The real nature of men has come to the surface, and we stand amazed at the goodness and grandeur of it. On this side the Atlantic we have not yet seriously tackled the luxury question, but we shall have to deal with it in radical fashion before our war debts are paid. Luxuries, whether they be costly, or the smaller ones in which poorer men indulge, are not a necessity to national development or to individual happiness, and their abolition does not either ruin trade or make men discontented and unhappy. If the war teaches us this it will mean much for our future national and individual well-being.

Hospital superintendents, who are responsible for maintaining hundreds of lives and the operation of many acres, may be vital factors in both saving and producing, and thus play the game. It may be the only war service some of us can render.

With France all the time within a few days of starving ; with Great Britain relying on us for 65 *per cent.* of her essential foods ; with the wheat of Argentina and Australia too distant to be available, Northern America must step into the breach to avert famine for a warring world, and the fate that has overwhelmed the greatest empires of the past. A time of food shortage is at the door. It is hard to take it to heart while money is plenty. But money will not take the place of bread. By eating no more than we need, and by stopping waste, a good deal



can be done to relieve the situation. At any rate, a good habit will have been formed.

But the common-sense way of undertaking to prevent famine is to increase the food supply. This cannot be done in every land. Some nations are cultivating every foot that has not a building on it. But on this Continent the case is different. Here there are yet countless acres waiting for the breaking plough. In Great Britain they are tilling every available plot, and it is of just as vital importance to us that we increase production here as there. We are equally concerned in the outcome of the war.

Recently governments passed a law enacting that every able-bodied adult must be engaged in some useful occupation. If enforced without fear or favour it would set to work the tramp and the pampered son of the foolish rich man alike. Everyone would become a producer of wealth. It would be good for the country, and still better for the idler himself. Idleness, whether of the rich or poor, is a crime against the State, and is also the fruitful parent of vice and degeneracy. Ideals are changing; the gentleman is now a respectable citizen who toils in his country's service.

Distant though we be from the din and smoke of the battlefields, there is opportunity for us to prove ourselves heroes in the strife. These stars must not be left to do it all.<sup>(2)</sup> Each should take to heart that—

“ It isn't the task of the few—  
The pick of the brave and the strong ;  
It's he and it's I and it's you  
Must drive the good vessel along.  
Will you save ? Will you work ? Will you fight ?  
Are you ready to take off your coat ?  
Are you serving the State ?  
Are you pulling your weight—  
Are you pulling your weight in the boat ? ”

There are not a few who, over three years ago, were almost wishing that they had never lived to see such a dire day as was then dawning, but who have come to see through the years that the dark day of tragedy was also a day glorious with opportunity and destiny. It is even now said that had the war been won two years ago, it would have been the worst thing for our nation, as its lessons had not been learned.

A new and better day is coming for this war-wrecked world. The sea before us is uncharted, and there may be much that differs radically from the past, but we can only do as Columbus did—sail on.

A new spirit is moving in the masses of society. Men's ways of thinking are changing more rapidly than at any other time in history. Before the war it was said that to spend twenty-five millions yearly on

social reforms in Great Britain would mean national bankruptcy. Now it is found that more than that can be spent in a day to ensure the national safety. It will be found after the war that great expenditures to improve social conditions will come as a matter of course.

The soldiers will return with enlarged views of democracy and social justice. The rich and the poor, the learned and the ignorant, have together looked death in the face. The sense of brotherhood and comradeship has been immensely strengthened. Those who were less favoured under the old social system will be inclined to demand justice and equality. Those who were more favoured will be inclined to concede the demand. Artificial distinctions of rank, and even distinctions founded on superior capacity and learning, fade away before the proof of the common virtues of manhood. The equality that is sought is the equality of brotherhood and of rights.

Just as in war time, so it must be in time of peace—the good of the country, the well-being of the many, must prevail against the privileges and over the rights of few. This is good politics. It is true patriotism. The world is going to be a better place for the great masses of men. If we can but keep up the habit that we are to-day learning of being world-citizens, interested in great enterprises outside of ourselves, then we would be helping to build the democracy of the future, which must more and more become a society in which duties are greater than rights, and to serve a finer thing than to get.

If in these introductory remarks I have not been able to detach myself from the world's most serious business at the present time, perhaps on reflection they may not have gone very far afield from the subject which binds us together in an association. If there is to be a change in the conditions under which we live this must have its effect on the minds of men; whether for good or ill, I will not stop to speculate. We are intensely concerned with environment. This war itself is entangled with it.

England's greatness, her devotion to honour, truth, and fidelity, is due to the environment in which her children are trained and grow to manhood.

The ivy-grown wall, the vine-clad hills and the rose-covered bowers constitute the birth-place of English character.

Gerard tells us the cause of the war is the uncongenial environment in which the German youth is cradled and reared. The leaden skies for which Prussia is noted, its bleak Baltic winds, the continuous cold, dreary rains, the low-lying land, and the absence of flowers have tended to harden the spirit and rob it of its virtue, produce a sullen and morose character, curdling the milk of human kindness.

It is a greater pleasure than usual for Canadians to meet with their American cousins in this year, when our two countries are joined in the

grim but glorious comradeship of war in defence of the heritage and aspirations that belong to us both. Our fathers came from common soil, their veins flow common blood. For over a century we have lived as good neighbours in the friendly rivalries of peace. Through proximity we have adopted more and more your ways without becoming a whit less true to the British flag.

After this war we will be still better friends. We will have been in a fight together and on the same side. We will carry flowers across the seas to lay on mounds in the same clime. The boys who come back will have the same stories to tell of struggles and triumphs. Let us hope that the present is the dark hour that precedes the dawn, and that ere long the sky may be fired with the red glow of the rushing morn; that soon the shot that brings victory—the last one—may be heard, and if it come from an American gun, no Canadian will begrudge you the lucky honour.

The war has achieved much in cementing the two great English-speaking nations of the world as nothing else could possibly have done.

Great Britain and the United States have never before fought shoulder to shoulder, but they are doing it now, and the fact is one ominous to their enemies. A common peril has united them, and a common aim will perpetuate the union. To no group of people will success in the war mean more than to the Anglo-Saxons, and the fact that this great family will in future dwell together in undisguised confidence and goodwill is worth in itself all that the war has cost.

The Allies are depending on this land for food and men, for ships and guns, for ammunition and aeroplanes, and this is leading Britain to recast its views of the United States, and is leading the latter to regard Britain in a more favourable light than ever before. The old suspicions and the ancient grudges are being melted away. Years of misunderstanding were trodden underfoot when American boys marched through the streets of an amazed and admiring London.

It had long been a reproach that on this Continent men cared for nothing but the almighty dollar and made gold their hope, but when the call came to sacrifice for the good of the Allies no nation ever responded more gladly or liberally. Britain asked for meat, all you could spare, and you answered with meatless days, with the result that the United States has been able to supply millions of pounds more of bacon and beef than were expected. To-day the British workman has his normal supply of meat, thanks to America's response.

Germany never played more clearly into the hands of her foes than when she scornfully defied the world's greatest republic, in the mistaken conviction that while the United States was of great potential strength, she would not dare to challenge the mightiest military machine that ever cursed the world. But Germany's blunder will prove the world's

salvation if it succeeds in binding together in friendship the two great, peace-loving, freedom-cherishing, English-speaking democracies—Great Britain and America.

In 1493, a tiny barque, frail and scarred by many a storm, the first craft from America, returned to the shores of Europe. She bore what was then termed the richest freight that ever lay upon the bosom of the deep—the tidings of a new world beyond that vast waste of water which rolled in untamed majesty to the west. That was a year of good news for the people of Europe. The thirst for gold was as keen in the 15th century as it is to-day, and the discovery of Columbus disclosed to monarchs and adventurers alike visions of wealth.

Little could they reckon that in this year infinitely more precious freight would be borne across the same pathway, when ship after ship, leviathans of the deep, would bring from that new world to somewhere in Europe offspring of the sturdy pioneers from the old land, who in braving the savage forces of Nature had found liberty, legions of brave and noble men, in martial array, with the star-spangled banner at the mast-head, to reveal to the war-bound nations visions of something with which those of the wealth of the boundless West or the gorgeous East could not compare—visions of freedom for all mankind.

Thank God! "Our fathers' God, to whom they came in every storm and stress," America did not turn a deaf ear to the laureate's apostrophe:

"Gigantic daughter of the West,  
We drink to thee across the flood;  
We know thee most, we love thee best,  
For art not thou of British blood?  
Should War's mad blast again be blown,  
Permit not thou the Tyrant Powers  
To fight thy mother here alone,  
But let thy broadsides roar with ours."

(1) Delivered at the Seventy-fourth Annual Meeting of the American Medico-Psychological Association, Chicago, Ill., June 4th-7th, 1918.—(2) Referring to the "service flag" behind the speaker's desk with more than ninety stars, representing members of the Association in the Army Medical Service.

*The Infective Factors in Some Types of Neurasthenia.* By W. FORD ROBERTSON, M.D., Pathologist to the Scottish Asylums.

THE distinctive signs and symptoms of neurasthenia are capable of fairly precise definition, and there need rarely be any doubt, or difference of opinion, as to whether a particular case is to be classed as of this nature or not. The chief symptoms are a constant feeling of fatigue, not relieved by rest, and the occurrence of various forms of hyperæsthesia, paræsthesia, and localised pain. Two important physical signs constantly occur—exaggeration of the patellar reflex and tremor



of the eyelids when the eyes are half closed. Added to these, there are, in greater or less degree, characteristic mental features which constitute the picture of psychasthenia, namely, incoercible ideas, obsessions, and monophobias.

Predisposing to the occurrence of neurasthenia there is a particular type of constitution—the neurasthenic diathesis. Under the same adverse conditions some persons will develop neurasthenia, while others will not. Slight degrees of the malady are extremely common. Indeed, to have the signs of neurasthenia in its mild form is a distinction, for it is certain that it is chiefly the people who have a neurasthenic constitution who are the most brilliant, original, energetic, and influential. It is they who do the intellectual work of the world.

The severe and distinctly pathological manifestations of neurasthenia are those alone with which I have to deal. It is important to recognise that neurasthenia may be a prelude of serious organic disease, such as general paralysis, dementia præcox, other forms of insanity, pernicious anæmia, rheumatoid arthritis, and tuberculosis, the onset of which may obscure, but rarely obliterates, the characteristic features of the less serious malady.

With regard to the causation of neurasthenia, the evidence has hitherto been lacking in precision, or altogether defective. The only assigned cause having any definiteness is traumatism, and this, at most, accounts for only a small proportion of the cases. Nevertheless, this factor is of special interest at the present time. The trauma may be physical, or it may operate by vivid and painful mental impressions as shock. It is my purpose to-day to endeavour to show that the importance of this traumatic factor is being much exaggerated, and that many of the morbid conditions universally attributed to it can be proved to be due to chronic bacterial infections, which have been aggravated by the physical and mental stress, and other conditions inimical to health, to which the soldier on active service is inevitably subjected.

The number of cases of neurasthenia that I have investigated bacteriologically is sixty-six. It is necessary that I should make it clear that these sixty-six cases form a mere fraction of the total number studied by similar methods. Indeed, I have never made any special investigation of cases of neurasthenia. My object has been to gain accurate knowledge of the relationship of mental diseases to infections. In order to make the basis for conclusions sufficiently broad, I have studied all sorts of cases, not only in asylums, but among the general public. I have simply picked out the cases of neurasthenia, as it seemed to me that this subject was the one that was most likely to prove of interest on the present occasion.

The areas of the body investigated have been chiefly the nasal passages, lower respiratory tract, nasopharynx, mouth, fauces, and the



intestinal and genito-urinary tracts. The nature and importance of acute and chronic infections of the nasal passages and lower respiratory tract are fairly well understood. It does not seem, however, to be realised that the nasopharynx is the part of the body more liable than any other to bacterial attack, and that various important chronic maladies are commonly dependent upon infections of this region. Infections of the genito-urinary tract are somewhat better understood, but in regard to them, also, it is possible to show that the present teaching is defective. The region that has suffered the most serious neglect in respect of the possible relation of chronic infections to common diseases is, however, the alimentary tract. That more attention should not have been given to it is probably due partly to the special difficulties of investigation and partly to lack of scientific imagination, which ought to have attracted bacteriologists to this region long ago, and led them far beyond the mere study of typhoid and paratyphoid fevers, dysentery, and cholera.

Most advances in pathological knowledge have been dependent upon one or other of two things—the application of new methods of investigation, and the recognition of why certain important facts have previously eluded observation. In regard to our knowledge of the relationship of common diseases to chronic bacterial infections, both of these essentials to progress are in dire need of being brought into operation at the present time. As an example of the importance of recognising why certain facts have previously eluded observation, I would mention a discovery of fundamental importance that we have exploited at the Laboratory of the Scottish Asylums for over two years. It is that many pathogenic bacteria which in orthodox teaching are regarded as aërobes are liable to occur as anaërobes, and to refuse to grow unless fairly strict anaërobic conditions are provided for them. This applies to such common pathogenic species as *Micrococcus catarrhalis*, the three highly important and distinct pathogenic varieties of pneumococci, *Streptococcus faecalis*, *Streptococcus pyogenes*, and neurotoxic diphtheroid bacilli. It is therefore essential to use anaërobic methods as a matter of routine in the bacteriological investigation of cases. Those who do not use them in such work must continually miss facts of primary importance for the successful treatment of the patient's malady. An equally necessary requirement in regard to methods of investigation is the constant use of hæmoglobin agar. The value of a culture medium of this kind was maintained by my colleagues and myself more than sixteen years ago, but as far as I can gather it is still little used—at least in a proper way. For the differentiation of the many distinct streptococci, and for the growth of pneumococci and of the bacilli of the influenza group, it is essential. It is also the basis of the only anaërobic method suitable for systematic case investigations.

There is a rather important point that requires to be alluded to and put aside before I describe the chronic infective conditions that I have found in my cases of neurasthenia. Most persons afflicted with this malady suffer from intestinal stasis and its consequent toxæmia. The toxins absorbed from the colon in these cases are no doubt varied in nature and origin, but they are chiefly formed by the action of saprophytic bacteria upon the food residues. Absorbed in excess of the amount that can be destroyed, they produce lassitude, mental depression, slight degrees of mental confusion, more or less severe headache, and sleeplessness or drowsiness. All cases of neurasthenia accompanied by intestinal stasis are aggravated by absorption of these toxins. It is, I believe, an error to regard any case of neurasthenia as dependent upon intestinal stasis alone. There are always pathogenic factors of much greater moment.

There is still one more preliminary point that it is necessary I should try to make clear. We need rarely, nowadays, remain in the dark as to whether a particular organism isolated from a case is acting as a pathogenic agent or not. We do not require to resort to experiments upon animals; indeed, such experiments could not give us the information we want. The methods of focal reaction and therapeutic immunisation furnish trustworthy evidence of the kind desired in almost every instance. Applied in a long series of cases, they permit of important practical generalisations regarding the bacterial causation of many chronic maladies. I believe it is chiefly to Dr. R. W. Allen that we are indebted for directing attention to the importance of focal reactions, both as evidence of the pathogenic character of a particular bacterium and as guides to correct dosage. I have endeavoured to follow and to extend his work. A focal reaction is specific. It is an active congestion at the seat of infection induced by the hypodermic injection of a minute dose of an emulsion of the corresponding bacterial toxin. It is almost always revealed by characteristic disturbances, which generally simulate certain symptoms of the malady. Sometimes the active congestion can be seen, as, for example, in the course of therapeutic immunisation for infections of the conjunctiva. In many other instances it is manifested by signs scarcely less distinct. Frequently we have to rely, however, only upon symptoms experienced by the patient. If, after we have induced a series of such reactions, all symptoms disappear, there is added the evidence of therapeutic immunisation in support of the conclusion that the bacterium used in the preparation of the vaccine was the cause of the malady. By such methods the pathogenic character of various types of bacteria has been established, and the particular kinds of disorder to which they give rise have been clearly recognised. For instance, it has been possible in innumerable instances to confirm the fairly well-known relation of pneumo-

coccus infections to various forms of chronic catarrh of the respiratory tract, and to go further and to show that many cases of chronic intestinal catarrh are due to the same micro-organism, and to separate out two other distinct species of pneumococcus and to prove that they are respectively the primary causes of rheumatoid arthritis and pernicious anæmia. I well know that the subject is endless, and that we are yet at the very beginnings of the application of bacteriology and therapeutic immunisation to common maladies.

I have now, I hope, sufficiently prepared the way for an analysis of the sixty-six cases of neurasthenia in which I have made a bacteriological examination.

In all of these cases chronic infections were discovered, and their relationship to the malady, as either the chief, or a very important contributory cause, was established by the methods I have indicated. In most instances the infections were complex. In seven of the cases the neurasthenia seemed to depend essentially upon a chronic infection by the bacillus of influenza. Under therapeutic immunisation all of the cases made complete recoveries, with the single exception of one in which treatment is not yet finished, but in which also there is every prospect of a good result. I would here remark that acute and chronic infections by the bacillus of influenza yield to correct therapeutic immunisation with a readiness unsurpassed in any other form of bacterial infection, and that protective inoculation is simple, rapid and effective. It must not be thought that chronic infection by the bacillus of influenza is constantly associated with neurasthenia. These seven cases in which this form of infection could be regarded as of ætiological importance represent not more than one-tenth of the cases of the same infection that I have investigated and treated.

There were ten cases in the series in which a pneumococcus was the only, or the leading, chronic infective agent. In eight of these cases the intestine was the seat of invasion; in the remaining two it was the nasopharynx. Again, it is to be said that similar pneumococcus infections occur without neurasthenia. These ten cases constitute only a very small fraction of the number of cases of chronic pneumococcus infection that have come under observation.

Another bacterium that may induce the neurasthenic syndrome is *Streptococcus pyogenes*. Its frequent action as a neurotoxic agent when it occurs as an acute infection is well known; the best examples are seen in cases of puerperal endometritis and erysipelas. It is not yet generally recognised that as a chronic infection it may, though only exceptionally, produce important neurotoxic effects. Ten cases occurred in which invasion by this streptococcus was at least an important factor in the production of the patient's malady. In five of the cases the seat of the infection was the nasopharynx, in two the

gums, in two the intestine, and in one the organism was found only in the urine.

Another streptococcus which in some cases of simple infection have proved to possess important neurotoxic powers in susceptible persons is the *Streptococcus faecalis* in its hæmolytic form. It was found under such conditions as to warrant the conclusion that it was acting as an infecting agent in eleven of the cases. The most common seats of infection were the nasopharynx and intestinal tract; examples of infection of the urinary tract also occurred. This streptococcus is a very common infecting agent, and it is certainly the exception for its invasion to be associated with nervous symptoms.

I have left to the last the most important neurotoxic infective agent that these researches have revealed. By methods as rigid as any that science can require, it has been established that certain bacilli of the diphtheroid group are neurotoxic agents of great potency, and that they are operative in a wide range of nervous disorders. I cannot here adduce more than a fraction of the evidence I have collected. It will be given in some detail in a future publication. It is important it should be understood that the investigation of this subject is beset by a special difficulty that has rendered the collection of satisfactory evidence a very slow and laborious task. In the case of almost every other group of bacteria we can apply cultural, morphological and biochemical tests that serve to differentiate important species and varieties. In the diphtheroid group alone every criterion that has yet been suggested as a means of distinguishing one species from another, and pathogenic forms from non-pathogenic ones, has been found on extensive trial to be devoid of practical value. We can but take the forms that we find and test their power to produce focal reactions and their therapeutic value. By this means the relationship of some species of diphtheroid bacilli to cases of neurasthenia, exophthalmic goitre, dementia præcox and several other nervous disorders has been rendered evident. For many years I have been aware that in most cases of fully developed neurasthenia the urine is loaded with diphtheroid bacilli. The same feature is observable in a large proportion of asylum patients. In many of these cases of diphtheroiduria the presence of the bacilli can be readily recognised only by a direct examination of the centrifuge deposit; the organisms will not grow under the ordinary conditions of culture. At one time I interpreted this fact as indicating that the bacilli were dead. It has, however, now transpired that this is rarely, if ever, the case. The reason that the organisms will not grow under the usual conditions of cultivation is that, in these instances, they are anaërobic. Under anaërobic conditions upon hæmoglobin agar they will generally grow quite well. In the wide group of the diphtheroid bacilli there are several species that either temporarily



acquire, or essentially possess, an anaërobic habit of growth. The fact is one of great practical importance.

The systematic application of anaërobic methods to the investigation of the intestinal flora has shown that intestinal infections by anaërobic diphtheroid bacilli occur with considerable frequency, and that they are almost always associated with severe nervous disturbances. The types of cases in which there occur such infections by anaërobic diphtheroid bacilli include neurasthenia, mucous colitis, exophthalmic goitre, disseminated sclerosis, and various forms of acute and chronic insanity. That the presence of such anaërobic diphtheroid bacilli in the intestine is quite abnormal is borne out by the study of nearly two hundred other cases by similar methods, which serve as controls. In some cases the number of these anaërobic diphtheroids is almost incredible. Although *Bacillus coli communis* grows quite well under anaërobic conditions, I have obtained cultures in which its colonies appeared in the proportion of only one to about three hundred of those of the diphtheroid bacillus. I have a culture of this kind to show from a case of agitated melancholia.

My statistics of the sixty-six cases of neurasthenia show that forty-nine had diphtheroiduria. Six were ascertained to have aërobic diphtheroid bacillus infections of the intestine and twenty-five to have similar anaërobic infections. Some of the earlier cases were not investigated by anaërobic methods, and this figure is therefore probably below the actual mark. Aërobic diphtheroid bacillus infections of the nasal passages, nasopharynx and gums are also exceedingly common, and may be either of little or of great pathological importance. A proved cause of recurrent cold is a bacillus of this kind, which is quite different from the *Bacillus septus* and from Hoffmann's bacillus. In striking contrast to the non-neurotoxic character of this catarrhal diphtheroid bacillus is the intensely neurotoxic action of other strains which may be found in great abundance in the same region in many cases of dementia præcox.

I regard the ætiological relation of anaërobic diphtheroid bacillus infection of the intestine to mucous colitis as established. I have been able to make a close study of four cases. The focal reactions are distinct, and the value of prolonged therapeutic immunisation has been clearly proved. There is, however, in this malady another fundamental factor not amenable to treatment of this kind, namely intestinal displacement, which, in proportion to its severity, permanently impairs the health of the patient.

Five cases of neurasthenia complicated by exophthalmic goitre showed severe intestinal infections by anaërobic or aërobic (one) diphtheroid bacilli. In four of the cases there was also intestinal infection by *Streptococcus fecalis hæmolyticus*, and in one by a pneumococcus.



All of the five cases showed an extreme degree of diphtheroiduria, as also did two earlier cases in which no bacteriological examination was made of the stools. One of the cases was complicated by subacute Bright's disease, but all of the remaining six have done well under therapeutic immunisation.

Another disease that begins as neurasthenia is disseminated sclerosis. I have had an opportunity of investigating only one case by the methods now employed. It is that of a lady teacher. Less than a year ago she had all the signs and symptoms of this grave malady, and had to contemplate giving up her work, upon which she depended for her living. I found that both the urine and the stools were loaded with a purely anaërobic diphtheroid bacillus of unusual morphological characters. Therapeutic immunisation has now been continued for eight months. Focal reactions, manifested by severe nervous disturbances, occurred on several occasions, necessitating a diminution in the dose. Steady improvement in the patient's condition has taken place. All signs of disseminated sclerosis have disappeared, and she is again feeling quite fit for her work.

Included in the sixty-six cases of neurasthenia investigated bacteriologically there were nine of patients in the Army or Navy who had seen active service. None of them had suffered from shell-shock, but all of them had endured severe physical and mental strain, and some of them also exposure to cold and wet, and privation. They were cases typical of those that fill the military hospitals for neurasthenics. All of them on investigation proved to be suffering from severe chronic infections incompatible with health, and every one of them has either recovered, or is now improving under therapeutic immunisation directed against the infections from which he was ascertained to be suffering. Each case has had its point of interest.

A naval officer, after severe strain, suffered from depression, lack of confidence in himself, and neurasthenic symptoms. Various remedies were tried, including a period of rest, but without avail. The real cause of his illness was never even suspected. He was sent to me for bacteriological investigation. I found he was suffering from a chronic infection by the bacillus of influenza, with some other infections of minor importance. Under therapeutic immunisation he speedily recovered, and has remained well and fit for the discharge of his important duties.

Three of the cases suffered from chronic infections by a pneumococcus, intestinal in two of them, and nasopharyngeal in the remaining one. In each instance the illness was severe and disabling. All recovered under therapeutic immunisation, and were able to return to active service.

Three of the cases were typical examples of diphtheroid bacillus

infection of the intestinal tract, with the usually accompanying extreme diphtheroiduria. Two other cases had similar diphtheroiduria, but came under observation before the importance of anaërobic intestinal cultures was fully realised. I have been able to keep four of these cases of diphtheroidosis under observation, and they have all done well. The three with intestinal infection have shown great sensitiveness to minute doses of the diphtheroid bacillus vaccines, abdominal pain and discomfort and general malaise being the chief symptoms of focal reaction. Improvement under therapeutic immunisation in this form of infection is always slow, and treatment has generally to be continued for at least six months.

The moral of these cases is obvious. I do not deny the importance of traumatism and strain, physical and mental, as factors in the causation of neurasthenia, but after a period of rest the symptoms due to such causes should either subside, or leave residues that are distinguishable from the phenomena of true neurasthenia. If neurasthenic symptoms continue they must have a toxic basis, and the cases should be investigated and treated accordingly.

*Communications from the Lunatic Asylum at Nykøbing, Seeland.*  
FR. KRARUP, Chief Physician.

*Some Experiments on Treatment of Dementia Paralytica with Subdural Injections of Neosalvarsan.* By GEORGE E. SCHRØDER, Assistant Physician, Communal Hospital, Copenhagen, and HJ. HELWEG, Assistant Physician, St. Hans' Hospital.

THE demonstration by Noguchi and many other investigators after him of spirochætes in the nervous texture in tabes dorsalis and in dementia paralytica has, as is well known, quite subverted the old conception of these diseases as para- or metasyphilitic in nature. They are just as syphilitic as other diseases caused by *Spirochæta pallida* are. It is quite a different thing, however, that in certain respects they occupy a peculiar position; as a rule they do not manifest themselves till ten to fifteen years after the primary affection, and they are very little affected by antisyphilitic treatment. It is well known that it was especially this last fact which caused them to be considered as not syphilitic in the common sense.

The said proof of spirochætes has not made it less difficult to understand why the results of the ordinary antisyphilitic cure, also the salvarsan and neosalvarsan treatment, are so defective. The total outcome of the experiences so far obtained is the but little encouraging fact that in reality we have never, or very seldom, succeeded in stoppin

the progress of the disease effectively and for ever. We have quite often heard of temporary recoveries or cures, but, the said diseases in themselves showing a tendency to remissions, we have here in this country generally been most inclined to explain the achieved results as spontaneous remissions, or perhaps as results from the influence of the ordinary hospital hygiene.

However, the rational basis for the treatment—the presence of the spirochætes—having now been substantiated, we purposed, although without any great expectations, to attempt a treatment which the Norwegian-English alienist Monrad-Krohn has proposed.

Monrad-Krohn has in the *Norwegian Magazine for Physicians*, No. 5, 1914, published an article concerning "The Treatment of Syphilis of the Nervous System Spec., Tabes and Paralysis Generalis." It contained an account of rational treatment with salvarsanised serum, and the rational point consisted in taking serum from a patient who had been under the salvarsan treatment half or one hour after the intravenous injection of salvarsan and injecting it into the spinal canal. Thereby both salvarsan and anti-substance were injected at one time, and through the perivascular lymphatic channels these make their way to the parasites. On the contrary, after a mere intravenous injection of salvarsan no salvarsan passes into the cerebrospinal fluid, and, as far as can be judged, no anti-substance either.

Monrad-Krohn has achieved good results in tabes, but no results in dementia paralytica. But he observes in a supplement to his essay that in three cases of dementia paralytica he has injected 20–30 c.cm. salvarsanised serum directly into the cranium—that is to say, through a trephine opening into the subarachnoid space. In two of the cases the result was satisfactory, and in the third one a temporary deterioration occurred, which was followed by some convalescence. In a later article in the *Journal of Mental Science*, April, 1915, "Remarks on the Intracranial Injection of Salvarsanised Serum," Dr. Krohn touches upon his technique and on theoretical considerations which underlie the treatment. Here it has only to be observed that as a result of different experiments it was proved that a subdural injection of fluid was able to extend itself to rather a high degree over the surface of the brain, even over both hemispheres, but first to the left frontal lobe when the injection was made on the left side.

As to the technique, it shall also be only briefly mentioned. A trephine opening with a trephine of  $1\frac{1}{2}$ –2 cm. diameter was made 10–12 cm. above the temporal end of arcus zygomaticus under the usual anti- and aseptic measures. The dura, which was not opened, was then pierced aslope from behind forwards with a fine cannula, and 25–30 c.cm. salvarsanised serum was slowly injected. The operation was undertaken under local anæsthesia.

Unfortunately the essay was not accompanied by accounts of the illness, and a direct written application to Dr. Monrad-Krohn only elicited that the method had been tried a few times with good results, but that the war had to such a degree increased the work at that English hospital to which he was appointed that further experiments had to be suspended.

Others, and especially English authors, have occupied themselves with the subject. However, we shall not enter into details, but only refer to articles by Swift and Ellis, Mapother and Beaton (*Journal of Mental Science*, October, 1914), and in this country Carl With (*Hospital Magazine*, Nos. 40 and 41, 1917, and *Medical Weekly Paper*, No. 39, 1917). They are expecting more or less from these methods, which, however, have not got beyond the stage of experiment.

Although absolutely convincing communications were not forthcoming, we yet resolved to attempt this treatment, partly on account of the principle being supposed to be rational, and partly and not least on account of dementia paralytica being in itself such a hopeless disease that it is simply a duty to attempt any new and "rational" therapy. It ought here to be observed that previous experiments with subcutaneous injections of natr. nuclein and other fever-producing means have now and then proved to be of some effect, yet not in such a way that real power over the disease was obtained (Hallager, *Medical Weekly Paper*). Of course we did not expect the new method to be able to cure the disease, but we had the hope of possibly stopping its progress—that is, of making it effectively stationary, and that at so early a period in its course that the working ability of the patient would be in part retained. We seize this opportunity to thank Mr. Krarup, the chief physician, for permission to make these experiments, and the then assistant physician, Mr. v. Thun, for his aid at the first trephine operation.

The technique of the treatment used by us was at the beginning quite like that indicated by Monrad-Krohn, for which reason we refer to this. We gave intravenous injections of salvarsan, took some blood from the patient one hour after, had it coagulated under aseptic measures, and took 20 c.cm. of the exuded serum for the injection. However, through different difficulties presenting themselves, we were obliged to alter our technique somewhat. I shall shortly give an account of it for the use of eventual later experiments. For, in spite of our experiments not being specially encouraging, we still think that they ought to be carried on.

The operation itself presents no difficulty. It may be undertaken by any physician in a lunatic asylum, provided a small operating-room can be adapted for the purpose. It is always done under general narcosis.

The situation of the trephine opening in the temporal region at the



line of the hair was such that there was no danger of injuring the sinus sagittalis or the temporal artery. In some cases, however, a small branch of A. mening. passed across the visible part of the dura. In such cases the opening was prolonged to one of the sides with a small curvature, so as to have a place where you could make sure of not injuring the vessel when injections through the skin were to be undertaken later on. This little alteration was most easily executed by biting off the edge of the bone with an ordinary gouge-tong. The injection through the dura caused no difficulty either; on the other hand the later injections through the healed-up flap of the skin and dura were sometimes difficult. They were always made in such a way that the skin was first congealed with ethyl-chloride; then the cannula was pierced through the skin so deeply that the dura was supposed to have been pierced also. The last part of this penetration was quite free from pain, neither the dura nor the brain reacting painfully to the introduction of a fine cannula. It was no doubt unavoidable that now and then you happened to thrust the cannula a little way into the cortex, but when nothing was injected it did not cause the patient any inconvenience. In the case of brain-punctures, which were formerly used, small pieces of tissue were even removed without inconvenience to the patient. When making these injections it is, however, for other reasons absolutely necessary to make sure that you are within the subdural space, and this is done by letting the cerebrospinal fluid run out or be sucked through the cannula.

If you are not on your guard in this way you may happen to inject fluid into the cortex itself, which is thereby destroyed to a greater or less extent—a lesion which may possibly result in a paresis of the arm or the leg on the opposite side of the opening for the place of introduction. It sometimes occurred that we injected a solution of fluid without the cerebrospinal fluid being evacuated, trusting that the needle had really only been subdurally placed, and the consequence was as described.

Later on sections from some of these cases were examined, and there appeared to be an extensive leptomeningitis, which had probably hindered the outflow of the cerebrospinal fluid. Therefore you may certainly take it for granted that in all cases where you are unable to drain out the fluid through the cannula it is owing to such a chronic leptomeningitis, and this negative result of the puncture, and this disease ought then to be considered a counter-indication for continuing the treatment.

Moreover, it is most likely that a needle formed at the point like a catheter could more easily be passed subdurally, and an injection could be made without thereby injuring the cerebrum, but we did not get so far as to use such a one. However, we modified somewhat the injection-fluid, which was of more vital importance. There appeared, namely, to be



various inconveniences in using neosalvarsanised serum. Firstly, it was rather difficult to obtain sufficient sterilised serum for the injection without making the venesection comparatively large. Of course this difficulty could be overcome. But secondly—and this was of greater importance—you could not prove that the neosalvarsanised serum contained arsenic, or at best traces thereof, and that only when very large doses of neosalvarsan had been given intravenously, and of course it is arsenic which is the effective substance. After injections of 45–60 cgrm. neosalvarsan we submitted various samples of blood of 20 c.cm. to Stein's laboratory. These could not be proved to contain the least arsenic. Traces were only found in a sample of blood after an injection of 75 cgrm. neosalvarsan. The blood sample was supplied by Dr. C. E. Jensen, who treated a syphilitic patient with these large doses.

After that we resolved to inject neosalvarsan subdurally dissolved in fresh, distilled, sterilised water. The doses varied from  $2\frac{1}{2}$  to 15 mgrm. neosalvarsan in the following solution: neosalvarsan 0.45–0.60 cgrm. in 20 c.cm. distilled water—a somewhat weaker solution than Ravault has used for his intraspinal injections. The injections were repeated after an interval of two to four weeks. The largest number of injections given to any patient were five subdural injections, and in no case whatever has infection occurred from these injections.

In the following we shall state the achieved results. They are, as may be noticed by the shortly quoted accounts of the cases, not especially excellent.

But before coming to any conclusion from these attempts it will be fair to examine whether the results are a consequence of a wrong treatment, or whether the problem must be considered as altogether insoluble.

CASE 1.—M. S—, æt. 34, workman. Syphilis treated with fifty salving-cures when æt. 24. Taken to the lunatic asylum at Nykøbing, S., January 10th, 1916. The disease commenced at the age of 32 with an initial phase of depression. When taken to the hospital there was pupil diff. Left pupil insensitive. Slight paralytic disorder of speech. Spinal fluid, cells, 7; Nonne-Appelt, 0–35; Wm. in the cerebro-spinal fluid, 0.3–20. 0.2–100; in blood, 0.2–50, 0.1–100.

Trephining was done on April 17th, 1916. Neosalvarsan was injected intravenously, and 10 c.cm. neosalvarsanised serum subdurally.

May 13th, 1916: Injection of neosalvarsan, 0.003 grm. subdur. through the skin: 0.3 grm. intravenous.

May 24th: Injection of neosalvarsan, 0.006 grm. subdur.; 0.6 grm. intravenous.

June 16th: Injection of neosalvarsan, 0.12 grm. subdur.; 0.6 grm. intravenous.

July 7th: The patient is much better; able to work part of the day.

November 29th; 0.006 grm. subdur.; 0.6 grm. intravenous.

November 21st: The patient is dull and without interests.

December 21st: The patient does not want to work. Feels unwell.

February 14th, 1917: 0.0025 grm. subdur.; 0.45 grm. intravenous.

February 17th: In spinal fluid, Nonne-Appelt 2-35; in cerebral fluid, Nonne-Appelt 3-35 after a respite of twenty-four hours.

February 20th: The patient lost his comb yesterday which he had in his left hand. He explains that his left hand and arm a few times have been as if they were dead, but quite temporarily. No paresis of muscles, but a somewhat reduced sensibility of the left hand.

February 25th: In the course of the last twenty-four hours has had seven times some contortions of the face. Had injection of sulph. mag. 5 c.cm. of a 10 per cent. solution.

February 26th: Some slight attacks of contortions.

March 5th: Irritable and discontented.

May 25th: Works a little.

July 1st: Working better.

August 8th: Discharged, after having paid a visit to his home.

CASE 2.—C. L. J—, æt. 36, unmarried, assistant. Taken to the lunatic asylum at Nykøbing, S., on November 17th, 1915.

The patient contracted syphilis when 22, and when 35 he became nervous, tired and restless.

In the Frederiksberg Hospital, where the patient was first quartered, pleocytosis and positive Nonne-Appelt reaction and positive Wassermann reaction in blood and spinal fluid had been demonstrated.

When the patient was taken to the lunatic asylum at Nykøbing, S., and for a long time after, he was over-excited, but quite brisk and comparatively little demented. However, after a period of six months he began to pilfer, which he had never done before; he also evidently became more dull and had to cease working at the hospital.

In the spinal fluid there were then—cells, 40, and Nonne-Appelt reaction 5-20.

Wm. in the spinal fluid, 0.15-20, 0.075-80; Wm. in blood, 0.2-40, 0.1-100.

Trephining was performed on May 23rd, 1916, followed by injection of neosalvarsan, 0.006 grm. subdurally; 0.45 grm. intravenous.

June 10th: Is again more brisk. Goes to work. Yet he is somewhat low-spirited. Complains of a feeling of strain in the masticatory muscles on both sides.

June 15th: Neosalvarsan was injected, 0.012 grm. subdur.; 0.60 grm. intravenous.

Six hours after the injection there was difficulty of speech and paresis of the left arm and leg. Slight facial paresis and Babinski's reflex in the left foot.

However, in the course of a fortnight the patient was again able to walk about and was relatively well, but could not at all times move the left arm. The difficulty has later on improved somewhat, but there is still a slight paresis left.

The dementia of the patient has become rather stationary. Bodily the patient is getting on well.

November 7th, 1917: Spinal fluid, cells, 7; Nonne-Appelt, 2-10; Wm. in spinal fluid, 0.20-20, 0.1-100; Wm. in blood, 0.01-0.

CASE 3.—C. A. W. J—, policeman, æt. 42. The patient was infected with syphilis when æt. 20, and was treated with many salving-cures and injections.

The disease commenced when the patient was æt. 40 with depression and irritability.

There was then strong pleocytosis in the spinal fluid. Nonne-Appelt, 1-50. Wm. in spinal fluid, 0.05-0.

November 23rd: Was taken to the Frederiksberg Hospital, treated with strong antiluetic cure and had tuberculin treatment. The patient was discharged with — Wm. in blood.

May 3rd-May 22nd, 1915: Renewed treatment.

August 4th: Again at the Frederiksberg Hospital, with disorder of speech, facial paresis, and strong depressive unrest. Wm. + in blood.

March 25th, 1916: Taken to the lunatic asylum at Nykøbing, S.: far advanced dulness.

April 25th: In spinal fluid, cells, 112, and of these many extraordinary polymorphonuclear-formed lymphocytes. Nonne-Appelt, 7-25. Wm. in spinal fluid, 0.07-60; 0.003-100; in blood, 0.1-60; 0.05-100.

May 9th: Trephined. Injection of neosalvarsan, 0.015 grm. subdurally; 0.309 grm. intravenous; 0.009 grm. subdur.; 0.45 grm. intravenous.

June 16th: Attempt at injection in vain.

August 29th: 0.01 grm. subdur.; 0.60 grm. intravenous.

February 10th, 1917: Attempt at injection in vain. Lumbar puncture. In the spinal fluid there are now 450 cells, about  $\frac{1}{4}$ — $\frac{1}{5}$  of them, polymorphonuclear formed.

February 18th: Incision above the place of trephining, then injection of neosalvarsan, 0.0025 grm. subdur.; 0.60 grm. intravenous.

March 1st and March 3rd: Spasms in the right arm.

November 3rd: His psychical condition is unaltered.

Spinal fluid, cells, 7. Nonne-Appelt 2-10. Wm. in spinal fluid, 0.1-20, 0.05-100; in blood, 0.025-60, 0.05-100.

In the following three cases a temporary recovery in response to the treatment occurred, but after the lapse of some time the disease progressed and the patients died.

CASE 4.—M. P. P—, blacksmith, æt. 45.

When the patient was 22 years of age he contracted syphilis, which was treated at the Communal Hospital, fourth ward; later on a fresh outbreak occurred, which was treated ambulant. At forty-three years of age he became irritable, capricious, and got megalomania.

June 19th, 1914-February 13th, 1915, at the Frederiksberg Hospital. Wm. in the spinal fluid was weakly positive. He was treated at the Frederiksberg Hospital with tuberculin, salvarsan, and hydrargyrum.

Discharged recovered with negative Wm. in blood.

November 14th, 1915-April 5th, 1916, again at the Frederiksberg Hospital, treated with injections of sublimate and salving-cures. When taken to the hospital he was a typical dementia paralytica, and was discharged unchanged. There was a considerable increase of the quantity of albumen and positive Wm. in the spinal fluid.

June 14th, 1916: Taken to the lunatic asylum at Nykøbing, S., with rather advanced dementia. In the spinal fluid, cells, 13; Nonne-Appelt, 5-30. Wm. in spinal fluid, 1-20; in blood negative, 0.6-100.

July 11th: Trephined, with injection of neosalvarsan, 0.006 gm. subdurally; 0.45 gm. intravenous.

August 29th: 0.006 gm. subdurally; 0.45 gm. intravenous.

October 6th: The patient is getting better; is working in the workshop and the garden. Has had an attack of unconsciousness.

February 14th, 1917: Injection of neosalvarsan, 0.0025 subdur.; intravenous failed.

In the spinal fluid 24 lymphocytes, and in the cerebral fluid 21 lymphocytes.

February 20th: Has attacks of convulsion in arms and legs, mostly in the left side.

February 22nd: Numerous attacks of convulsion, mostly in the left side.

February 26th: Increasing attacks of convulsion. Mors.

*Section:* Under the trephine opening on the left side a small, yellowish-grey softening is to be seen quite superficial in cortex; ependymitis granularis; myocardial degeneration; broncho-pneumonia.

On the right side on inner surface of dura flat fibrinous deposits and slight bleedings; pachymeningitis hæmorrhag. interna.

CASE 5.—G. V. P—, dairy manager, æt. 24.

Nothing known about syphilis. Patient was taken ill during his military service, and was at once treated with potassic iodide and salving cure. Wm. positive in the blood. He was taken to the lunatic asylum at Nykøbing, S., on November 15th, 1915. He presented a typical paralysis with megalomania and disorder of speech.

February 6th, 1916: The spinal fluid showed cells, 23. Nonne-Appelt, 3-20. Wm. in spinal fluid, 0.1-60; 0.05-100; in blood, 0.025-60; 0.01-100.

March 22nd: Trephined. Injection of neosalvarsanised serum, 10.00 gm. subdur.; neosalvarsan, 0.60 gm. intravenous.

April 11th: 10.00 gm. subdur.; neosalvarsan, 0.60 gm. intravenous.

May 8th: Injection of neosalvarsan, 0.003 gm. subdur.; neosalvarsan, 0.60 gm. intravenous.

May 18th: The patient has written a letter, which, compared with previous letters, was excellent.

May 25th: Injection of neosalvarsan, 0.009 gm. subdur.; 0.60 gm. intravenous.

June 8th: More clever at assisting in the garden and in the ward.

June 17th: Neosalvarsan, 0.012 gm. subdur.; 0.60 gm. intravenous.

July 14th: In the spinal fluid, cells, 0. Nonne-Appelt, 3-75. Wm. in spinal fluid, 0.2-60, 0.0025-100; in blood, 0.05-60, 0.1-100.

August 20th: The patient is getting more restless and dirty, evil-tempered and obscene, then steady psychical and somatical descent to Mors. On November 16th, 1916, sections examined: Leptomeningitis, ependymitis, aortitis luica. Dura a little adherent at the trephine-opening, but no local alterations in front of this.

CASE 6.—V. C. C—, butcher's journeyman, æt. 37. The date of infection is unknown. When 32 years of age he received antiluetic



treatment, because Wm. was positive. He was able to work after the treatment.

He was taken to the lunatic asylum at Nykøbing, S., on November 29th, 1916. Dementia paralytica with far advanced dementia. Spinal fluid, cells, 12'0; Nonne-Appelt, 5-40. Wm. in spinal fluid, 0'3-40, 0'2-100; in blood, 0'1-20, 0'005-100.

He was trephined, and was then altogether twice injected with neosalvarsan 0'006 grm. subdurally, and at the same time 0'45 grm. intravenous. There was a quite transitory convalescence after the last injection, but from that on his paralysis advanced steadily. At a later spinal puncture his spinal fluid was found not to contain more cells.

*Section-diagnosis:* Diffuse inspissation of the soft membranes. Ependymitis granularis. No softenings. Aortitis luica; bronchitis chr.

In the following four cases the patients died without the injections having influenced them at all. Sections showed nothing but the usual and characteristic appearances seen in cases of dementia paralytica. We had no impression of these injections having influenced the paralysis in any way. In any case, three of these patients, when taken to the lunatic asylum, had reached such an advanced condition of dementia that it would have been a doubtful advantage even if we had really been able to retard their disease.

The disease was in all four cases quite typical and well substantiated, also as to the cerebrospinal fluid. We shall only give a short account of them.

CASE 7.—G. K—, æt. 55. Far advanced paralysis. The patient had previously had paralytic attacks with temporary paresis of the left arm.

The spinal fluid showed—cells, 6; Wm. in spinal fluid, 0'3-80; in blood, 0'2-30.

August 20th, 1916: Trephining, with injection of neosalvarsan, 0'006 and 0'045 grm.

August 30th: Spasms in the left arm with continuing paresis, which in the following months partly improved.

February 15th, 1917: Thirteen cells in the spinal fluid. June 1st: Mors.

*Section:* A small superficial softening in front of the trephine opening. Extensive paralytic alterations in the brain. Aneurysma aortæ.

CASE 8.—O. S—, æt. 41. Taken to the hospital on December 28th, 1915.

On October 13th, 1914, there was found in the spinal fluid a considerable increase of cells and albumen reaction and positive Wm. reaction.

When taken to the hospital the patient presented the picture of far-advanced paralysis with typical attacks, after which there was for a time some paresis of the left arm.

February 9th, 1916: Spinal fluid, cells, 16; Nonne-Appelt, 2-60; Wm. in spinal fluid, 0'1-60, 0'05-100; in blood, 0'2-30, 0'1-100.

April 10th: Trephined. After that there was injected subdurally 0'003, 0'012 and 0'015 and 0'006 grm., and intravenous, 0'60 grm., four times. A few days after the third subdural injection there was a temporary



paresis of the left hand, and later on attacks of convulsion in the left side.

*Section:* Strong diffuse pia-inspissations. No softening.

CASE 9.—C. P. C. C.—, æt. 36. Taken to the hospital on July 13th, 1916. The patient contracted syphilis when 23 years of age. After he had been taken to the hospital a lumbar puncture was performed. The spinal fluid showed—cells, 97; Nonne-Appelt, 5-40; Wm. in spinal fluid, 0.3-20, 0.2-100; in blood, 0.1-60, 0.05-100.

Trephined with subdur. injection of neosalvarsan 0.01 and 0.45 grm. intravenous was given. The injection was made without succeeding in evacuating fluid first. The day after there was a slight paresis of the left arm and the left side of the face.

*Section:* Leptomeningitis chr. Cortical softening of cerebrum. Aortit. luica.

CASE 10.—N. M.—, æt. 37. Taken to the lunatic asylum at Nykøbing, S., on July 7th, 1916. The patient presented a typical paralysis.

August 20th, 1916: Trephining with injection of neosalvarsan, 0.006 and 0.45 grm. respectively subdur. and intraven.

September 2nd: Slight paresis of the left arm.

September 4th: Evident paresis of the arm, which, however, got somewhat better in the course of a month. In the course of six months the patient began to fall away, and then died.

*Section:* Dura was adherent to the cranium and to pia in front of the trephine opening. No softenings.

All these very concise extracts from records do not, as already mentioned, present any very encouraging results from the treatment, yet, before denouncing such an apparently rational treatment as the one in question, you ought, as also observed, first to examine whether "primary mistakes" should impair this issue, as is generally the case as regards recently evolved methods of treatment, and to ascertain whether these mistakes were avoidable, so that in time the treatment might become of advantage.

Therefore it will be necessary to consider the groups previously mentioned a little more closely—first of all the one where the treatment was ineffective. It presents two features which may partly explain the bad result. One of them is that at any rate three of the cases mentioned showed far-advanced paralysis; the fourth case was also rather advanced, but the dementia was somewhat less than in the other cases. Consequently these were cases where it was conceivable that the disease was too far advanced for the treatment to be of effect. To this must be added the other not less important point that the complication which frightened us from further treatment occurred so quickly, namely after the first or the second injection, that, in fact, a systematic treatment of three of the cases, including the one less advanced, was out of the question. The only one which got a series of four injections was already, when taken to the hospital, so far

advanced that, as indicated, it would be beyond all expectation that the treatment would be effectual.

Therefore these bad results can hardly be chargeable against the method. There are hardly any other methods, which, under similar circumstances, would have given a better result.

The next group, in which the patients died, but where, however, there was a temporary improvement in response to the treatment, also proves, but certainly less obviously, that similar circumstances have influenced the result. At any rate in two of the cases the dementia was far advanced before the treatment, and the treatment was not resumed because of the improvement having subsided, and the dementia again being in advance. Here the remissions occurred after the second injection.

The two cases had also previously had remissions after antiluetic treatment, but in the third no such treatment had been attempted, and this is therefore the most interesting. The remission was here quite beyond doubt: the patient did not quite recover before he got a relapse; he consequently presented a somewhat childish behaviour, which, however, was possibly constitutional with him.

Here five injections were given, but two of them being of neosalvarsanised serum, which, as proved, did not contain arsenic, only three injections may be reckoned with.

Finally, there is the last group, the three cases in which for the present the paralysis seemed to have become stationary or improved. In one there were given four double injections, in the other two, and finally in the third were given five double injections.

All three cases have been amongst the less seriously attacked; in one of them—the slightest—the patient has been discharged.

However, before regarding these results as being in favour of the treatment, there is no doubt a circumstance which must be taken into consideration—the very essential one that paralyses also present remissions spontaneously. If we examine how our ten patients have got on, it appears, including the previous quarterings at the hospital, that four of the patients have previously had antiluetic treatment—that is, with Hg. and neosalvarsan—and all four had undoubted remissions, and in this hospital the seven have, as mentioned, had remissions of shorter or longer duration—altogether a number which surely is somewhat more than the number of spontaneous remissions would be in the case of ten other paralytics which had not been treated. Consequently it really appears as if a more energetic antiluetic treatment than a mere salving-cure is able to exercise a temporary effect on the paralysis. And other investigators, who have greater material at their disposal, have come to the same conclusion. Here I shall only refer to the statements of Leredde.

Leredde insists that the reason of failure to cure the paralysis is, that the treatment is not sufficiently energetic. And Nonne (<sup>1</sup>), surely the investigator who has the best knowledge of lues cerebrospinalis in all its shades, has also commenced to esteem the energetic salvarsan treatment more highly than before. Formerly he warned against it, and was of opinion that the treatment consisting of increasing the leucocytes was the best one—the tuberculin and natrium nucleinum treatment—but now, having become acquainted with the remedy along with Gennerich in Kiel, he thinks that you may expect something from intraspinal injections of neosalvarsan.

Here it would be of importance if you could prove that the treatment had any influence on the pathological processes discovered in the cerebrospinal fluid and the blood, as it has now and then been proved by other investigators both as regards the ordinary antiluetic and the fever treatment. But in this domain the material is doubtless very deficient. There ought to have been many more re-punctures than has been the case. Only in six cases have cells been repeatedly counted, and in four of them the number of these has, after the treatment, become nought, and in two it has increased. As known beforehand, you are to a certain degree able to influence the pathological process in the spinal fluid.

Finally, just a few words on the complication which prevented us from carrying through so energetic a treatment as we should otherwise have considered ourselves bound to do. As seen from the records, in several of the cases—altogether four—an unfortunate consequence of the injections appeared. There was a continuing paresis of the arm—sometimes, but more seldom, of the leg also—on the opposite side to where the injections had been made. At first we supposed that it was owing to a local cortical softening produced by the needle, and through injection of the concentrated fluid. The first sections, namely, showed such a small softening, but the section in Case 10 showed that also without softening a paresis might come—probably a consequence of the local irritation of leptomeninges. Such an acute partial leptomeningitis also explains the paresis in the other cases better than the said small softenings, it seeming strange that so superficial and limited a softening could cause so great disturbances. Therefore in all cases it is to be supposed that the acute local leptomeningitis has been the cause, and this you will be able to avoid in the future if neosalvarsan in more dilute solutions is used—for instance, an injection made with 10 or 20 c.cm. sterilised salt water.

In the preceding remarks we have tried as objectively as possible to weigh what is in favour of and what is against the treatment described. We have not reached convincingly good results, but perhaps useful ones; and that this has not been done to a greater extent by the proceeding

used by us cannot, as we have proved, be unjustly charged as altogether against the method. On comparing it with so many others we must recollect that not seldom has it occurred that methods, which at the beginning have had difficulties to encounter, have proved useful in the long run. Before passing a final sentence there is still an important question to be settled.

For the present the question may be stated thus: Is it altogether worth the trouble to treat paralytics, and especially in the way indicated, which consequently should be given preference over the mere intravenous injection in that it affects the spirochætes in the cortex directly? However, this must be answered in the affirmative. We know that the paralysis in itself is such a hopeless disease that any chance, be it ever so inconsiderable, of being able to make the disease stationary would be an advantage. If we succeed in this, it will surely also be possible to do it at so early a stage of the disease that the working ability of the individual may be wholly or partly retained.

As therefore the method, with suitable alterations and limits as indicated by us, seems to give a faint hope, the experiments ought to be carried on. For instance, it is possible that a continued series of examinations of the spinal fluid in the case of the same patients will prove that there are certain forms of paralysis which can be more influenced than others.

(1) Nonne, "Ueber die Frage der Heilbark. der Dem. paralyt.," *D. z. f. Nhlk.* Bd. 58, H. 1 and 2.

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*Medico-Psychological Association of Great Britain and Ireland:  
Report of English Lunacy Legislation Sub-Committee.*

A Sub-Committee of the Parliamentary Committee of the Association was appointed in January, 1918, the terms of the reference being "to consider the amendment of the existing Lunacy Laws."

The Committee was composed as follows:

H. WOLSELEY LEWIS, Esq., M.D., F.R.C.S. (Chairman).  
 ROBERT H. COLE, Esq., M.D., F.R.C.P. (Secretary).  
 Lieut.-Col. Sir ROBERT ARMSTRONG-JONES, M.D., F.R.C.P.  
 Miss A. HELEN BOYLE, M.D.  
 JAMES CHAMBERS, Esq., M.A., M.D.  
 Lieut.-Col. MAURICE CRAIG, M.D., F.R.C.P.  
 REGINALD L. LANGDON-DOWN, Esq., M.B., M.R.C.P.  
 BEDFORD PIERCE, Esq., M.D., F.R.C.P.  
 GEORGE E. SHUTTLEWORTH, Esq., B.A., M.D.  
 Lieut.-Col. T. E. K. STANSFIELD, M.B., C.M.  
 ROBERT H. STEEN, Esq., M.D., M.R.C.P.  
 Lieut.-Col. DAVID G. THOMSON, M.D., C.M.  
 J. G. SOUTAR, Esq., M.B., C.M. (co-opted at a later stage).



## INTRODUCTORY.

The terms of the reference were so wide that it was agreed to invite opinions from medical men and others as to what, in their experience, were the defects in the present Lunacy Laws, and a large amount of evidence was thus collected.

From this it was obvious that there is a pressing need for some better method of dealing with cases of unconfirmed mental disease. The importance of this matter is further indicated by the facts that much has appeared recently on the subject both in the Medical and General Press, that books dealing with it have had a wide circulation, and that Bills providing for better treatment of unconfirmed mental disease have been presented to Parliament in recent years, notably in 1914 and 1915.

These facts, and other evidence of dissatisfaction with the operation of the existing Lunacy Laws, have impressed upon us that it has become urgent to secure such amendments of the Law as will give effect to some of the recommendations made in the *Report on the Status of British Psychiatry* issued by the Medico-Psychological Association in 1914.<sup>(1)</sup> That report established the pressing claim, which further experience has accentuated, for better facilities for the treatment of cases of mental disorder in the early stages. How that purpose may be accomplished has been the subject of careful consideration by this Committee.

It has been definitely ascertained that :

1. There are very few facilities for patients who are threatened with mental breakdown obtaining skilled treatment until they are certified. The early symptoms of disorder often occur long before certification is possible.
2. Owing to efficient treatment being delayed the most valuable time for adopting measures to secure early recovery is lost.
3. There is strong objection to certification in itself on the part of the public, which is alive to the material and moral damage which it so often inflicts on the patient and his relatives, so that even when certification has become possible they refuse to resort to it and thus still further postpone the adoption of efficient treatment.
4. In cases where certification has to be resorted to the subsequent course of events often shows that this might have been avoided with advantage if there had been facilities for treatment under other conditions.
5. The experience gathered as the result of the war has opened the eyes of the public and the medical profession in a fresh way to the difficulties and needs of these cases.
6. Many medical practitioners, having had no opportunity of gaining knowledge of the manifestations and treatment of mental disorders in their early stages, fail to recognise the



seriousness of the condition and to secure for their patients efficient treatment. They are also often deterred, by the necessity of certifying the patient, from advising suitable treatment. This unwillingness may be due to a genuine and proper doubt whether the condition is sufficiently definite to justify this procedure or to a natural reluctance to cause distress to the patient and his friends. In some cases direct evidence of insanity cannot be obtained at occasional interviews, and certification and treatment are thus delayed.

7. In many early cases advantage would be taken of the opportunity for treatment in Asylums were the Voluntary Boarder system, with some modification of procedure, extended to all Institutions for the insane.
8. Many persons of the well-to-do classes, who are the subjects of mental disorder and are certifiable, are now placed in private houses without an order having been obtained for their reception. No intimation of their admission is given to the Board of Control. No precautions are necessarily taken to ascertain that the conditions are favourable for the patient or that efficient treatment is thus being obtained for him. It is felt that while many cases may be treated in private houses quite properly, provision should be made to give a competent authority the opportunity of ascertaining that houses in which such patients are received are suitable for the purpose, and that the persons in charge are competent to treat cases of mental disorder.

Although some desire to see the Lunacy Laws entirely re-cast and re-named, with abolition of the Magistrate's order and other legal formalities, the majority are satisfied that such far-reaching changes are not necessary, and it appears that all the reforms most urgently needed could be obtained by a short Amending Bill. It is certain that at the present time such a Bill would be more likely to secure the early consideration of Parliament, and would meet with less difficulty in its passage than a wider measure.

*The Committee therefore recommends :—*

1. That the Medico-Psychological Association take no steps at present to obtain a complete revision of the Lunacy Acts, but seek to obtain amendments only to those Acts.

As the Committee cannot but think that all, with experience of the subject, agree that the Law now presses hardly on certain cases, pauper and private alike, is not abreast of modern requirements and aspirations, and is not working in the best interests of the State, it has endeavoured to frame proposals to meet these defects.

In doing so, it has kept in mind on the one hand the practical convenience and view-point and possible prejudice of those for whose benefit the measures suggested are intended, and on the other the necessity of winning the support of instructed lay opinion, the medical profession and the constituted authorities.

These proposals fall under four heads :

Clinics.

Voluntary Boarders.

Further Provision for Private Patients.

Supplementary.

#### CLINICS.

These aim at providing facilities for treatment of which ailing members of the public will be ready to avail themselves at the earliest possible moment, even when the condition is merely what is commonly described as one of "disordered nerves." This necessitates as complete a dissociation as possible from the existing statutory requirements for dealing with the insane.

It also necessitates the provision of facilities similar in character and equal in completeness to those available for purely physical ailments—that is, a thoroughly well-found and well-staffed Clinic for both in- and out-patients. These facilities must be brought as near to the homes of the people as possible. They should therefore be established all over the country in large centres of population, so that the people may easily seek advice and so be encouraged to get instruction in mental hygiene at a stage when preventive measures are possible, and thus escape in many cases a serious breakdown, to the advantage both of themselves and the community; for thus would be retained as workers those who otherwise become a burden to their fellows.

No mere extension of the Voluntary Boarder system in Asylums (which is much to be desired on other grounds) would appear to meet these requirements. Nor is it probable that any arrangements that might be made at the General Hospitals throughout the country would alone be sufficient.

The Clinic should be called by some name which will clearly indicate its purpose as a place to which patients suffering from any of the early indications of nervous disorder may resort.

Just as in ordinary Hospitals some cases of delirium and excitement with loss of control occasionally occur and are there dealt with without special powers or any great difficulties, so similarly cases of mental disease in their early stages where the symptoms are likely to subside under proper treatment would be received and suitably provided for in the proposed Clinics.

The decision whether a case is or is not suitable for further treat-

ment in such a Clinic would depend upon practical convenience and the nature and duration of the symptoms.

It is thought that the special character which it is hoped will attach to these Clinics will be more certainly secured if no formal powers of detention therein on the ground of mental disease are asked for, at all events in the first instance, until some experience has been gained of the practical working of the scheme.

By keeping the proposed Clinics free from any formal powers of detention they will be given distinction in fact as well as in name from the existing Institutions: they are intended to cover a different field from that covered by the Asylums, and it is hoped that the confines of this field will be extended to a far earlier period of the disorder than could possibly be the case in connection with the Asylums.

In large towns Clinics should be affiliated to the General Hospitals, in order that students may have opportunities of studying those early stages of mental disorder which as practitioners they will be called upon to treat. For this purpose either special wards might be set aside or special buildings used with assistance from public funds. Clinics would also provide a valuable field for post-graduate work and for scientific research with the necessary laboratory accommodation. If the recommendations of the Local Government Committee on Transfer of Functions of Poor-Law Authorities 1918 are adopted many existing buildings or parts of buildings might be adapted for use as Clinics, and in other cases the provision of buildings for Clinics should save expenditure which would otherwise be incurred in enlarging existing Asylums or erecting new ones.

*The Committee therefore recommends :*

2. That Clinics be established by local authorities for the treatment of nervous and mental diseases in their early stages ; and that in the organisation of Clinics special provision be made for children.
3. That the first resolution, *re* Legal Changes, Appendix 7, of the Status Committee's Report, 1914, be amended by the substitution of the word "reception" for the word "detention." (2)
4. That a Clinic should be housed in a special building or in an annexe to a General Hospital.
5. That a Clinic should be staffed by a special staff trained for the work.
6. That it should be the duty of Local Authorities to provide and maintain Clinics either themselves or by arrangement with voluntary organisations for the purpose.
7. That the Committee of Management of a Clinic should be a special Committee appointed for the purpose.

8. That the inspection and approval of the buildings used for Clinics should be the duty of a Central Government Department.

#### VOLUNTARY BOARDERS.

Under the present Lunacy Laws patients may be received as Voluntary Boarders in Registered Hospitals and Licensed Houses. This facility should be extended to suitable persons, whether of the private or rate-aided class, desirous of placing themselves under treatment in County or Borough Asylums. The Board of Control in its third Annual Report has expressed its approval of this change.

Many patients who have recovered from a previous attack in an Asylum, and are on the verge of a relapse, wish to place themselves under Asylum care again, but are, at present, unable to do so until they become certifiably insane, and then they must be referred to the Relieving Officer.

There will no doubt be other cases unable to afford the expense of a Registered Hospital or Licensed House who will prefer to go direct to the Asylum for treatment in the first instance, if they can do so under the conditions attaching to Voluntary Boarders, and this should be permitted and encouraged.

The Board of Control should be informed of all persons received as Voluntary Boarders into Institutions for the Insane, but their previous consent thereto, or that of the Justices in the case of Licensed Houses, seems unnecessary and interferes with the utility of the plan, as many patients object to making written application to the Board of Control or the Justices for permission, as at present required; moreover, no such requirement obtains in the case of Registered Hospitals.

Further, there appears to be no good reason why this mode of admission should be reserved for persons who cannot be certified as insane, as it conflicts with the fundamental principle that treatment should be begun at the earliest possible moment. It should be sufficient for anyone, being aware of his mental illness, voluntarily to sign a document expressing his desire to be admitted as a boarder for purposes of treatment.

For practical convenience it is much to be desired that the notice required to be given by Voluntary Boarders of their intention to leave should be increased from 24 to 48 hours.

The reform suggested has long been advocated, and has met with practically no opposition.

*The Committee therefore recommends :*

9. That all Institutions for the Insane should be encouraged to admit patients as Voluntary Boarders on their signing an application to that effect addressed to the Medical Officer of the Institution, provided :



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(a) That there is suitable accommodation and the applicants are suitable persons.

(b) That they should be required to give 48 hours' notice in writing of their desire to leave the Institution, after the expiry of which period they must cease to reside as such; further provided that, before the Notice expires, the Boarder does not intimate in writing his desire to withdraw the Notice.

10. That Regulations should be made setting out the conditions on which the Medical Officer may admit Voluntary Boarders, and as to the provision for the maintenance of those unable to support themselves.

FURTHER PROVISION FOR PRIVATE PATIENTS.

It has to be recognised that the objection to certification in the early and curable stages of mental disorder is strongly felt by all classes, and the temptation, for those who can afford it, to send patients to unrecognised places of treatment is very great both for the patient's friends and their medical advisers. Those who receive such patients knowingly run the risk of prosecution, and there is no guarantee that they can or do give suitable care or treatment to the patients. The treatment of certain cases of mental disorder in suitable private houses is undoubtedly desirable, and the true interests of the patients should be obtainable in conformity with the law.

Where residential treatment is conducted for payment in the case of patients suffering from mental disorder which is deemed to be temporary, but who may be considered certifiable, it is desirable that the fact of their reception should be brought to the cognizance of some central authority. It is hoped that with this safeguard facilities may be granted for the treatment for payment by private persons or voluntary associations of early, undeveloped and recoverable cases of mental disease without the drawbacks attaching to certification.

It is suggested that the Board of Control should be empowered to give legal sanction to the treatment of this group of cases without certification. This can only be done by provisions limiting the application of Section 315 of the Lunacy Act, which imposes penalties on those receiving persons of unsound mind for payment without certification. It is not proposed to do away with this Section, and as its enforcement is in the hands of the Board of Control it is practically necessary to give any powers over-riding its application to the same body.

Any facilities for treatment of cases granted under this section should be equally applicable to such cases in Asylums, Registered Hospitals and Licensed Houses.



*The Committee therefore recommends :*

11. That the Board of Control should have power (a) to approve Homes which are supported wholly or partly by voluntary contributions or which are privately owned, as also Asylums, Registered Hospitals and Licensed Houses, in which it shall be lawful to receive without certification more than one patient suffering from mental disease in its early stages, and (b) to give legal sanction to the reception without certification of such patients as single patients in houses not so approved, provided that a medical practitioner gives a written recommendation in each case, stating that suitable treatment can be obtained for the patient in the proposed house.
12. That on any such patient being received into or ceasing to reside in any Approved (or Recognised) Home, Asylum, Registered Hospital or Licensed House, or as a single patient in a house not so approved, the fact shall be intimated to the Board of Control.

SUPPLEMENTARY.

*The Committee is further of opinion :*

13. That it is undesirable that patients alleged to be of unsound mind should be removed to a workhouse or pauper infirmary before their reception in an Asylum. If an intermediary stage is desirable it would be better supplied by the proposed Clinics. Practical convenience such as a motor service should be available for the transfer of patients to Asylums and Clinics on lines similar to those adopted in the Public Health Service.
14. That where no criminal offence is charged it is undesirable that Justices should in Court conduct the examination of mental cases for the purpose of making reception orders.
15. That it should be made possible for rate-aided patients as well as private patients to be admitted to Asylums under an "Urgency Order."
16. That it is desirable that neighbouring Asylums should be enabled to establish and maintain joint laboratories for research.
17. (a) That the words "Lunacy" and "Lunatics" be discontinued and the words "Mental Diseases" and "Persons of Unsound Mind" be substituted.  
 (b) That instead of the word "Asylum" the words "Mental Hospital" or "Hospital for Mental Diseases" be used, County, City, or Borough as may be.  
 (c) That the words "rate-aided" be used instead of the word "pauper."

18. (a) That there is much need of simplification of forms under the existing Lunacy Act.
- (b) That some of the legal phraseology is cumbrous and involves needless repetitions, and is at times objectionable, *e.g.*, "Take Notice," etc.
- (c) That intervals in time require uniformity, *e.g.*, "clear days," "within 14 days," "not more than 7 days," etc.
- (d) That in particular the duration and lapsing of Reception Orders require radical amendment.
19. (a) That the administration of the estate under Sect. 116 should be simplified, expedited and rendered less expensive; and—
- (b) That the endorsement on the Summons should be re-drafted.
20. That patients and voluntary boarders should be permitted reception direct to Branch Establishments of Asylums, Registered Hospitals or Licensed Houses.
21. That it should be possible to transfer the jurisdiction for licensing a house (or "hospital") from one authority to another on good reason being shown.
22. That it should be permissible for patients transferred from an asylum to a workhouse to be transferred back without re-certification.
23. That the existing Lunacy Act—which should be called the Mental Diseases Act—is framed more to protect society and safeguard the liberty of the subject than to treat and cure the patient.
24. That the amending Bill be called "The Mental Treatment Bill," 1919.

(<sup>1</sup>) *Journal of Mental Science*, October, 1914, p. 667 *et seq.*—(<sup>2</sup>) The resolution referred to is as follows: "That it is desirable that provision be made for the detention of patients in Psychiatric Clinics for a limited time without certification."

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## Part II.—Epitome of Current Literature.

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*The So-called Lucid Interval in Manic-Depressive Psychosis: Its Medico-Legal Value.* (*American Journal of Insanity*, April, 1918.)  
Gordon, A.

In this paper the question is considered as to how far the mentality of an individual can be regarded as normal during the intervallary periods of a manic-depressive psychosis. The writer has carefully studied the reaction of two patients during a prolonged so-called lucid period. In each case a superficial judgment would have failed to reveal any mental disorder, and from the point of view of the friends of

the patients they were regarded as quite normal. A careful analysis of the entire life of the patients, however, reveals a different picture of their mentality, and indicates that while the characteristic elements of the psychosis are no more in action, the disease, nevertheless, produces such a disturbance in the power of judgment, affectivity, sense of morality, and attitude towards others that the patients could not be considered normal.

Such individuals obviously do not require commitment, but they should, nevertheless, be kept under observation. In spite of apparent lucidity there are such fundamental deviations of mentality that they may seriously compromise themselves or their family. The civil capacity is, therefore, more than questionable, and proper administrators should be appointed to safeguard their interests. An individual with a previous history of manic-depressive periods possesses an underlying morbidity, of which the psychosis is an expression, and the morbid characteristics cannot naturally disappear during a so-called lucid interval, no matter how protracted its duration may be.

H. DEVINE.

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### Part III.—Notes and News.

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#### THE MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

THE QUARTERLY MEETING of the Association was held at 11, Chandos Street, London W., on Tuesday, November 26th, 1918, Lieut.-Col. David G. Thomson, M.D., R.A.M.C. (Acting-President), in the chair.

The following signed their names in the book as having been present at the meeting or as having attended meetings of committees: Sir G. H. Savage, Lieut.-Col. Sir Robert Armstrong-Jones, Drs. M. A. Archdale, H. T. S. Aveline, C. W. Bower, David Bower, H. C. MacBryan, James Chambers, R. H. Cole, A. W. Daniel, J. Francis Dixon, R. Langdon-Down, Richard Eager, C. F. Fothergill, H. E. Haynes, David Hunter, H. Wolseley-Lewis, John Macarthur, S. E. Martin, Alfred Miller, Jessie M. Murray, C. S. Myers, Alex. W. Neill, W. F. Nelis, H. J. Norman, David Ogilvy, David Orr, L. R. Oswald, J. G. Porter Phillips, Bedford Pierce, J. J. F. Prideaux, J. Noel Sergeant, J. C. Shaw, G. E. Shuttleworth, R. Percy Smith, J. G. Soutar, T. E. K. Stansfield, R. C. Stewart, F. R. P. Taylor, R. Worth, and R. H. Steen (General Secretary).

*Visitors:* Drs. S. Lane, H. C. Maudsley, and F. W. Thurnam.

*Present at Council Meeting:* Lieut.-Col. D. G. Thomson, M.D., R.A.M.C., in the chair, and Drs. H. T. S. Aveline, David Bower, James Chambers, R. H. Cole, A. W. Daniel, R. Eager, Alfred Miller, L. R. Oswald, J. G. Porter Phillips, Bedford Pierce, J. N. Sergeant, G. E. Shuttleworth, H. Wolseley-Lewis, and R. H. Steen.

Dr. J. G. Soutar and Lieut.-Col. M. A. Collins attended on the invitation of the Acting President.

Apologies for unavoidable absence were received from: Drs. Thos. Drapes, R. B. Campbell, T. Stewart Adair, Henry J. Mackenzie, A. Helen Boyle, Fletcher Beach, J. H. Skeen, Francis Sutherland, William Tuach-MacKenzie.

The CHAIRMAN said the minutes of the May meeting had already appeared in the Journal, July issue, therefore he assumed the meeting would agree to take them as read.

The minutes were approved and signed.

The CHAIRMAN said he had to ask the meeting to again tolerate him as Chairman, as he regretted to say the President, Lieut.-Col. Keay, was compelled to be

absent owing to illness. Dr. Keay underwent, after a serious illness, an operation for appendicitis. He was glad to know that the patient was now doing fairly well, though not yet fit for duty in his own hospital nor for transacting the work of this Association. He was now recuperating in the south of England. He proposed to the meeting a vote of sympathy with him in his illness, which, if approved, would probably act as an encouragement to him in his convalescence. He was sure such a vote would be much appreciated by the recipient.

The resolution was carried unanimously.

#### OBITUARY.

The CHAIRMAN said one of the first duties of the occupant of the chair at these gatherings was to bring to the notice of the meeting the names of those members who had died since the previous meeting. To-day he had to notify the death of Dr. John Chapin, of New York. The *American Journal of Insanity*, referring to the event, said: "Just as the Journal is about to go to press the sad news reaches us of the death of Dr. Chapin, at his home in Canandaigua, New York, on Thursday afternoon, January 17th, 1918. Dr. Chapin has been regarded, for many years, as the Nestor of American psychiatry. He completed his 88th year on December 4th, 1917. In 1904, in Philadelphia, at the head of the Department for the Insane, he rounded out fifty years of service in hospitals for mental disorders, and a dinner given in his honour on December 1st of that year was attended by a noteworthy gathering of friends. For seven years longer he continued at the head of the hospital over which he had presided since 1884, retiring in the summer of 1911 and removing to Canandaigua, New York." He had been an Honorary Member of this Association since 1887.

The next name was that of Dr. William Reid, who, for twenty-five years, was Superintendent of Aberdeen Royal Asylum. He died on September 3rd. After a distinguished career at Aberdeen University, he became junior assistant to Dr. Jamieson, who at that date was medical head of that Asylum, and on that gentleman's death, fifteen years later, he succeeded him. During his long term he saw the great institution reconstructed at a cost of £50,000, with the addition of a branch asylum at Daviot. The success of the project owed much to Dr. Reid's able administration. Dr. Reid was responsible for the introduction of female nursing on both sides of the Asylum, though he was severely criticised for it. Dr. Reid also filled the post of lecturer on mental diseases at Aberdeen University. He left a wife and two daughters.

Members would have the same feelings of regret, and desire to express them in the proper way, concerning the late Captain Frank Oswald Spensley, who died of pneumonia at Burden Military Hospital, Weymouth. Educated at St. Thomas's Hospital, he became Senior Assistant Officer of the Darenth Industrial Colony at Dartford. After joining the R.A.M.C., he became Captain after a year's service. He was invalided home from Salonica, and had latterly been attached to the R.A.F. at Blandford.

He had also to notify the death of Dr. Logan, of the Bucks Asylum, Stone, near Aylesbury; that of Dr. Hume Griffith, Medical Superintendent, Lingfield Epileptic Colony; and that of Dr. Herbert, Assistant Medical Officer of York City Asylum.

He moved that votes of condolence and sympathy should be sent to the relatives of all those he had mentioned.

The members signified their assent by rising in their places.

#### THE MENTAL HOSPITAL AT LEBANON, SYRIA.

The CHAIRMAN called upon Dr. Percy Smith to make a statement on this subject.

Dr. PERCY SMITH said this subject did not appear on the agenda paper of the meeting, but the Chairman had kindly said he might make a short statement to the members.

His hearers would be aware that there existed a hospital called the Lebanon Hospital for Mental Diseases in Syria. Some members were subscribers to it, and some were on the English General Committee. It had now been open about sixteen years. The present Medical Superintendent, Dr. Watson Smith, was a



member of this Association. All through the war the question had arisen as to what was the position of this hospital—it was a charitable institution, absolutely international in scope, and it housed patients of every creed and nationality. It had been equipped as a hospital for acute mental cases on the pavilion system and on modern lines. So long as we were not at war with Turkey we did not feel anxiety about the existence and well-being of the institution, but when Turkey entered the war it became a subject of anxiety. Most of the subscribers were English, but there was also a large amount of American help, and Turkey was not at war with America, so that communication could be kept up indirectly through America. Dr. Watson Smith had held the place throughout, and there could be no doubt that during the last two and a half to three years he had been through a very bad time. When Turkey entered the war, Dr. Smith's wife and family had to return home to England and the hospital matron had to go to Egypt, therefore he was left there with only native assistance, though the head attendant was a German. The Turkish authorities recognised the institution as a charitable one in the category of religious foundations, and he was glad to say the Turks had absolutely kept to their principles in that way. Though the institution had been used for Turkish insane soldiers and had been under the Red Crescent, yet all along they had supplied the hospital with food at a time when there was frightful starvation in the surrounding Syrian country. Though during this time Dr. Watson Smith was really a prisoner in Turkish hands, he had remained in charge of the hospital; he was not deported. During the recent advance through Palestine, Syria and Mesopotamia there had been anxiety for news, and at last he was in receipt of a letter, since the occupation of Beirut, saying that on October 13th Dr. Watson Smith was all right, and, of course, free. He also said he was in a position to send home the necessary documents.

The head attendant and his wife left the hospital when they knew the British were arriving, and had now gone for ever, and the doctor was now working the hospital with the head nurse and a young Roumanian student. The hospital had suffered structurally, and life had been one of semi-starvation and at exorbitant prices. He, Dr. and Mrs. Graham were the only English residents to meet the British troops on their arrival. The letter went on to say it was impossible to describe in a letter what their feelings were to see, after four years, the fine English soldiers and sailors. They had been seeing thousands of people dying all round.

He said he thought it would be a graceful act if the General Secretary could be induced to write a letter of congratulation to Dr. Watson Smith on the pluck in carrying the management of the institution through during the war. Colonel Dawson, of Dublin, had written to him (Dr. Percy Smith) saying he saw a note on the matter in *The Lancet*, and, as he felt the hospital must be badly in need of funds, he sent two guineas. If any other members should feel similarly, there would be a grateful response.

The meeting duly authorised the sending of the letter.

#### THE REPORT OF THE ENGLISH LUNACY LEGISLATION SUB-COMMITTEE, 1918.

The CHAIRMAN suggested that the document in question should be read to the meeting. It was a lengthy document, but it had been impossible to circulate it as a whole, owing to it being a question of urgency. The printed synopsis practically embodied the essentials of the Report, but it was desirable that the meeting should hear the full Report. After Dr. Steen had read it, he would ask Dr. Wolseley Lewis, the Chairman of the Sub-Committee, to move its adoption.

Dr. STEEN read the detailed Report (see p. 36).

Dr. WOLSELEY LEWIS: As Chairman of the Committee which was responsible for the Report you have just heard read, I rise to move its adoption. In the first place you will notice that the Committee is a representative one; it is composed of members who have had experience in public and in private asylums as well as in consulting practice; it includes members of the Status Committee which drew up the Report that received your approval in the year 1914. It also includes four past Presidents of our Association. Since the beginning of the year we have held monthly meetings, which have been very well attended, and in the intervals between the meetings a good deal of work has been done by correspondence. I



am very glad of this opportunity of expressing my indebtedness to various members of the Committee for the large amount of work they have put in, and more especially to our energetic Secretary, Dr. Cole, who, I know, has had a very hard time over this Report.

From a review of the composition of the Committee you will realise that this subject has been viewed from many different angles, and you may rest assured that no paragraph has been allowed to stand in the Report without having received its full meed of criticism.

From the complexity of the subject, it strikes me, you may think the Report is unduly short; in fact that we have perhaps produced a mole-hill rather than the expected mountain. But I would remind you that in a report of this kind its merit lies, perhaps, as much in what is left unsaid as in what has been said. The aim has been to produce a workable scheme that may meet with general approval, and though more Utopian schemes have, at times, held the attention of the Committee, they have been rejected as being outside the scope of practical politics. I do not propose to go—nor, probably, would you desire that I should go—into a detailed analysis of the Report; it will be sufficient for me to say that our whole object has been to offer, without any disabilities, as good facilities for the treatment of early mental diseases as now exist for the treatment of bodily diseases, and to offer those facilities without the assistance—I had almost said without the interference—of the lawyer. It is for this reason, and because we felt that any form of detention without full safeguards of certification would have no chance of receiving the assent of Parliament, that we are convinced it is better not to seek any powers of detention. For that reason we ask leave to amend the first resolution of the Status Committee in that sense—that is to say, by placing the word “reception” in the stead of “detention.”

On October 29th we had a conference with the Board of Control; we spent a very busy and very satisfactory morning with them, for our Report was very sympathetically received by them. If we are unanimous in our adoption of this Report we shall very materially strengthen the hands of the Board of Control in securing legislation, because that body will then be in a position to say that expert opinion, as represented by this Association, advocated the course which this Report lays down.

No doubt many of you—the majority perhaps—have seen the recommendations in the last report of the Board of Control, and that their proposals and ours are in general agreement. I understand their chief points are, firstly, that they should be satisfied that the places where treatment is to take place are suitable; and, secondly, that there shall be no powers of detention.

After a very hurried luncheon on that day we went off to a conference at the Guildhall. That conference was convened by the Bucks County Asylum, and was largely attended by representatives of local authorities who were interested in the matter. We found there a very strong body of public opinion in favour of reforms similar to those which are laid down in this report. At that meeting I had an opportunity of making a statement to the effect that our Report had been drafted and would be submitted to this general meeting of the Association to-day. The result, I am glad to say, was that the Committee, which was invited by that conference to draw up a report, have invited this Association to appoint three or more members to assist them in that task. You will thus at once see that we have an opportunity of influencing an important section of the public.

There can be very few of our members who are not aware, from their own experience, of the immense amount of real hardship which results from this difficulty in obtaining treatment in early cases of mental disorder, as evidenced at the conference and recently in the public Press. We find, too, that the public are becoming alive to this fact. As the Board of Control put it in their last sentence, in connection with the question of soldiers: “In order to meet the pronounced opposition of the public to the certification of soldiers, certain institutions should be set apart for their treatment without certification. The public prejudice against the so-called ‘stigma of certification’ has, in no small degree, been the cause of, and created the necessity for, this special arrangement. It is a prejudice which has always existed, and has to be recognised and reckoned with in civilian life. In the opinion of the Board, it has ever been a hindrance to the early treatment of mental disease, with the result that in all asylums there are numbers of persons

suffering from incurable insanity who, had they been the subjects of expert advice and treatment when the premonitory symptoms manifested themselves, would not improbably have recovered, and become useful members of the community." In my opinion, it is at once the duty and the privilege of this Association to take a leading part in the reconstruction of the law on this subject, and I appeal to you not only to approve this report, but to see that your views as represented by it are circulated as widely as possible. In my opinion the times are ripe, and I appeal to you to let the voice of this Association be heard in no uncertain way.

Dr. COLE: In rising to second the motion for the adoption of this Report, it is not my wish to detain you very long, because it is probable that many speakers will follow me.

I must say the Committee has worked extremely hard at this Report, and although we did not all see eye to eye at the various meetings, we have now produced a Report that we are unanimous in supporting. Some of us have had to alter our preconceived opinions with regard to the principle of notification; but we feel it is expedient—at all events, for the present—to leave that, even if we think well to ask for powers of temporary detention later on. To my mind, our Report does not in any way put institutions for the insane on an inferior level. We should all do our best to recognise that these are hospitals for mental diseases, and that this matter of supposed stigma is one which must be continually fought against. I do not like to think of asylums without blocks for acute cases; I do not like to think of their being deprived of acute cases to be treated. Neither do I think there will be much difference with regard to the reception of such cases in asylums in comparison with what obtains at the present day. But we should like to see the laws amended so that a fair trial may be given to incipient cases of insanity to recover outside an asylum without certification when prejudice is very strong.

For many years there has been agitation for changes in the Lunacy Laws. In 1900 we had the Lord Chancellor's Bill advocating voluntary boarders in asylums, and seeking the provision of special treatment for incipient mental disease which was framed largely on the lines of the Scotch Act. I will not say anything about that section 13, because I think it is seldom made use of. The Bill contained many other amendments and was dropped. In 1904-5 Sir Robert Finlay, who was then the Attorney-General, brought forward another Bill, dealing with temporary care in cases of incipient insanity. It also fell to the ground, though it was a Government measure, because Parliament was not sufficiently interested, and the medical profession did not push its points sufficiently.

Since then the war has broken out, and soldiers and sailors are being treated for mental disorder, and the public has been demanding that they shall not be certified. We are all well aware that there is no necessity to certify them, because the military law is in every way more stringent than is the law with regard to lunacy.

An important point in our report, which is an addition to what we have advocated in the past, is the proposed establishment of clinics. The recommendation is largely the outcome of the labours of the Status Committee. For the work done by that Committee our Sub-Committee feels very grateful. The proposition means that we are asking that the local authorities should be compelled to provide accommodation for incipient mental disease, just as they have to make accommodation for "pauper lunatics" as they are called now. This is to compel local authorities to do so, not to give them the option, which might be evaded.

I would like to explain to you that the recommendations were circulated, but the whole Report was not printed because, in the first place, it was going to receive further amendment this morning, and secondly, because it had to receive the approval of the Council before it could be printed. The printed recommendations which you have, however, are really the gist of the Report, and the supplementary opinions which deal with further amendments of the Act are not quite so pressing. These, however, have been read out to you.

We hope very sincerely that you will adopt this Report. No member need feel he is voting for something which has not received the fullest consideration. If there are any points of a minor character which we can elucidate, we shall be glad to try to do so if questions are put to us. It is most important we should get something through forthwith. We have met the Board of Control; we attended the

meeting at the Guildhall which you have already been told of; there is reconstruction going on everywhere, and we ought not to delay the matter longer. I therefore strongly appeal to you to pass this Report and authorise it to be printed.

The CHAIRMAN: Does anyone desire to speak on any section or on the Report as a whole?

Dr. BEDFORD PIERCE: Could we take the four sections separately?

The CHAIRMAN: Certainly. Do you accept the introductory portion?

Agreed.

Clause 8.

The CHAIRMAN: We have not specified the Board of Control nor any other department, because, in view of the possible introduction of a Ministry of Health, these departments may be altered—at least in name.

Clause 7.

Lieut.-Col. ROWS: I ask what we are to understand by the term "local authority?"

The CHAIRMAN: Just the same as boroughs and counties in the Lunacy Act.

Lieut.-Col. ROWS: It is suggested they should be attached to Universities and medical schools: would it not be better to have co-operation between the University or the medical school staff, or their committees and any local authority?

Dr. WOLSELEY LEWIS: That was the intention. In cases where a voluntary hospital takes these cases, it should take them for the local authority.

Dr. COLE: It was felt that the voluntary hospitals are already under some control by the local authority; for instance, we now have a Tuberculosis Department, a Venereal Diseases Department, and it has a voice in the management to some extent. We think that in the case of an University town, the University authorities will be represented on the Committee of Management, as well as the local authority.

Lieut.-Col. ROWS: I would like it to be so stated.

The CHAIRMAN: There is more in that Clause 7 than meets the eye. There was a feeling on the part of certain members of the Committee that these clinics, having been established, should not be managed by the same persons who manage the asylums—the county and borough. That is the inner meaning of this clause. I think Col. Rows' point is rather raised under Clauses 2 and 6.

Dr. WOLSELEY LEWIS: The idea is this: supposing the local authority were in any way responsible for the payment for people in these places, then the local authority would have to have representatives on the Committee; that is all. Therefore it would be combined.

Lieut.-Col. ROWS: But if the Universities decided to start a clinic before the local authority came in?

Dr. WOLSELEY LEWIS: That would be a voluntary organisation.

Lieut.-Col. ROWS: We understand that in Lancashire the Asylums' Board feel it is their duty, if the patients are treated in an University clinic, that they should co-operate.

Lieut.-Col. M. A. COLLINS: Would it not be clearer if No. 7 were put more fully—that the Committee of Management should not be the Asylum Committee, but should be a special County Committee?

The CHAIRMAN: That is an indirect censure on the Committees. We say the same thing more politely.

Dr. BEDFORD PIERCE: We do not know what will be the authority, and we leave out the words "local authority." We say the Committee of Management of the clinic should be a separate Committee appointed for the purpose.

Dr. COLE: That would be so.

Dr. WOLSELEY LEWIS: Yes.

Lieut.-Col. ROWS: That meets my point.

The CHAIRMAN: The clause sounds redundant, because, naturally, any public place is managed by a committee *ad hoc*.

Lieut.-Col. ROWS: Yes.

The CHAIRMAN: Yet it will not be considered redundant when you know what the Committee had at the back of their minds: that if the same body of men who now manage the asylums were to manage these, they would at once be associated in the public mind with asylum administration.

Dr. DIXON: Do I understand the meaning of the last amendment is, that the

local authorities who are asked to establish these clinics are, later on, to have no say in the management of them?

The CHAIRMAN: No.

Dr. LANGDON-DOWN: Before we leave the clinics section, I would like to say it seems to me proposals to establish clinics of this kind offer a convenient opportunity for dealing with a class of case for which there is no proper provision, and which we might definitely recognise in our representations. I refer to cases of children who are subject to mental defects or disorders. I think it desirable we should say that in the establishment of clinics the organisation should provide a separate department for children. That would form a central clearing department for consultation on cases occurring in the work of school doctors and others, also it might develop into a psychological clinic where all children who become chargeable before a court are first seen for examination. So I suggest we should add a clause to the effect that it is desirable, in organising clinics, that a separate department for children should be included.

The CHAIRMAN: We must ask you to draft a clause and hand it up, as an addition to or amendment of a certain clause.

Dr. STEEN: It is moved by Dr. Langdon-Down—"That in the organisation of clinics provision be made for a special department for children."

Dr. LANGDON-DOWN: As a separate clause.

Dr. WOLSELEY LEWIS: Will Dr. Langdon-Down accept, instead of "a special department," "special provision should be made for children"? Some of these clinics may not be very big.

Dr. LANGDON-DOWN: Yes, I agree.

Dr. PERCY SMITH: Would it not be better to have it under No. 2? It is better as a continuation of that sentence.

Dr. BOWER: Is it necessary to say anything about children at all?

The CHAIRMAN: It appeals to sentiment. This is not a question of framing a Bill now: we are not committed to these actual words.

It was agreed that in recommendation 2 the words "and that in the organisation of clinics special provision be made for children" be added.

Clause 9.

The CHAIRMAN: Is the word "encourage" necessary?

Dr. COLE: That word was specially used after some discussion.

Dr. WOLSELEY LEWIS: We did not want to use too strong a word. "Encouraged" was put in at the urgent request of Sir Robert Armstrong-Jones, because, he said, it is not a question of giving them power to do it; we want to ask them to do it, not compel them.

The CHAIRMAN: It leaves it open for any institution for the insane—public, private, or registered—to have nothing to do with boarders.

Dr. PERCY SMITH: This is giving paternal advice; otherwise, legally, it should be that they should be permitted.

Dr. WOLSELEY LEWIS: "Permitted" was our word before.

The CHAIRMAN: I take it that Nos. 9 and 10 meet with approval.

Agreed.

The CHAIRMAN: Now "Further provision for private patients," Nos. 11 and 12. Do any licensees of private asylums consider their interests are affected by these clauses?

Dr. SERGEANT called attention to the great dangers involved in giving legal sanction to the reception of single uncertified patients in ordinary houses which had not been specially approved merely on the authority of a medical certificate from a medical practitioner.

The CHAIRMAN: This is certainly a very important point. I have heard expressions in my district similar to those just uttered, and it is only fair to licensed houses that this subject should be gone into at this open meeting. Before I ask Dr. Wolseley Lewis to reply, is there any other member who wishes to criticise this No. 11, or No. 12?

Dr. PERCY SMITH: I ask what this means: that "The Board of Control should have power (a) to approve homes which are supported wholly or partly by voluntary contributions," etc., and then (b) "to give legal sanction to the reception without certification of such patients as single patients in houses not so approved"? I gathered from the Chairman of the Committee that there is to be no notification



of the case to the Board of Control, therefore how are they to start to give legal sanction to the reception of such a patient?

The CHAIRMAN: It is a very important part of the Committee's Report.

Dr. SOUTAR: I agree this is a very important point, and I think it was carefully considered by the Committee. It was specially brought up, and it was determined that no privilege must be given to single houses or to approved houses which was not given to existing institutions for the insane. One purpose which was before the Committee was that patients and their friends should have free choice with regard to the treatment of the patient, and that whatever advantage may be given to approved houses should be extended to licensed houses, asylums, and hospitals for the insane. In that way all are put under the same advantages and disadvantages. The great advantage which, I think, will accrue is that in future, instead of cases being sent into private houses, no authority knowing anything about them, they must be reported to the Board on admission and on discharge. The Board of Control will have it in their power to make an investigation, and take such action as may be necessary. At present many of those patients are treated surreptitiously; nobody knows anything about them, and it is only by accidental discovery of something amiss that a prosecution is instituted. If, in the future, an endeavour is made to deal with these cases surreptitiously, the person doing so will be in a worse position than he is to-day. Through the proposals now made the interests of the existing institutions are carefully safeguarded, and great advantage will accrue to patients generally, in that they will not be treated in unsuitable places.

Dr. NORMAN: I would like to raise the point whether it would not be better to see to that beforehand, whether you should not have a system whereby anybody wishing to take patients should have their houses examined, as is general with licensed houses at the present time. Under the present system the thing might take place; the house might be carried on for some time unless the Board of Control is greatly extended. Another suggestion would be that they should appoint people in particular districts whose function it should be to supervise and inspect such houses in which it was proposed that mental patients should be taken.

Dr. PERCY SMITH: In any legislation the Board of Control will take powers to see licensed houses before they approve of them.

Dr. DIXON: It says a medical practitioner appointed for the purpose or approved by the Board of Control. But an ordinary general practitioner might not be in a position to judge.

Dr. BOWER: That only gives the Board of Control power to approve and power to give legal sanction; it does not say that, because the medical practitioner gives a certificate, the Board of Control will give legal sanction. I think there is sufficient power. I raised this question at the meeting of the Parliamentary Committee and at the Council meeting this morning, and the explanation pointed out to me seems clear enough.

Dr. NORMAN: Is no suggestion coming from the Association as to what is meant by the early stages of mental disorder? Is it a week, or two or three months, or what?

Dr. WOLSELEY LEWIS: There is no time.

Dr. SERGEANT: May not a case be an "early case" for years?

Dr. WOLSELEY LEWIS: All I have to say is, that the intention of that clause was to strengthen the hands of the Board of Control in doing away with all these people who complained and who were unrecognised people and often gave unsuitable treatment. And it was thought, if that clause were put in, they would be much better able to prosecute under section 315 than they are now, and which they are anxious to do. And it would take away the temptation to act against section 315, because they would say, "Here is a suitable place which the Board of Control know of—I will send my patient there; there is no disability." All it means is that where a patient goes to has to be intimated, and the name of the patient is not given. With regard to the question of the medical practitioner, meaning any ordinary medical practitioner, that was the Board's own idea, and I thought it was rather a compliment to the medical profession. What Sir William Byrne said to me was, "Surely a doctor is a very responsible person, and we should accept his word." If he writes that such and such a person as a patient is suitably



treated that is enough for us, and if we doubt him we could refuse to accept his word again.

Dr. FOTHERGILL: It is to the advantage of the patient that he should be received in this way, because it gives him great opportunities of getting well and without any stigma, and the man who keeps the home would say, "I shall be glad to have my home known as an approved house." He would also say, "Any doubtful case I shall now feel safe about." At present certain cases are sent to him, and he has to pass them on to some institution, whereas if they had only been able to remain a little time longer in what would now be an approved home they could be cured without having to go to an asylum. I do not understand the second part of clause (b). I ask whether this refers to sending patients to the houses of non-medical men. Does it mean a patient can be sent to Mrs. B—'s house who is not a doctor?

The CHAIRMAN: Yes.

Dr. COLE: With regard to clauses (a) and (b), you can send a certified patient to any house, a layman's or doctor's. There are many houses suitable for patients, but some which are unsuitable. It is too much to ask that every house shall be approved; you cannot ask that a house for a single patient shall be approved, but the house of the kind Dr. Fothergill mentioned, for half a dozen patients, should be approved. If there is a house with only one patient it need not be approved, but it must be intimated to the Board of Control. The suggestion is on the lines of approved homes under the Mental Deficiency Act, and it would be better to call them "recognised homes" instead of "approved homes" by way of distinction.

Dr. SERGEANT: I understand that the words "in its early stages" in regard to mental disease do not mean anything, because, as I have already said, I understand the "early stage" may go on for years. And if those words do not mean anything why are they introduced? It is undesirable to make use of words which have no meaning. I think we should attach a meaning to them—make them mean what they appear to mean—that is, early as opposed to prolonged and chronic. I think the Board of Control have suggested six months in this connection.

Dr. FOTHERGILL: There are some people who are eccentric all their lives but yet are never insane, so they may remain during all their lives in the early stage of mental disease without deserving to be certified. A time-limit does not come into it at all, and I agree with the present wording.

Sir ROBERT ARMSTRONG-JONES: I wish to apologise, Mr. Chairman, for my late arrival. The idea in the minds of the Committee was that this should be left indefinite in our report to the Council, but that in a Bill a definite period should be stated. The feeling was that nine months—the period held to apply to the case of the soldier—should be held as that to which the word "early" would apply.

The CHAIRMAN: Yes. As I say, this is not a Bill.

*Supplementary.*

The CHAIRMAN: Are there any criticisms on the supplementary part? If not, I put it that the Report, as a whole, be approved.

Dr. LANGDON-DOWN: There is another point to which in times past criticism has been directed, which might be corrected now. The form of certification requires that the examination shall be made by one doctor separately from that of any other medical practitioner. I notice it has been thought that it is a slur on the medical profession, and that it is a handicap to people who desire to certify cases where evidence of insanity is difficult to obtain. It is thought there would be collusion between doctors in obtaining evidence on which they base their certificates. If we could get those words deleted in any further forms I think it would be to the credit of the medical profession.

Dr. PERCY SMITH: If that means that the examination of the patient separately from that of any other medical practitioner should be eliminated, I think it would be a great mistake to make the suggested alteration. The whole object is to safeguard the individual, and for this there should be separate examinations. It is so easy for two people talking together to get the same facts and put them down, and to get the same impression of a case. The examination by two medical men together is not sufficient protection to the patient. Whenever I go to a consultation and the doctor says, "I think this patient ought to be certified," I say, "One must have a separate interview at once." If you begin to talk together and arrange

a separate interview afterwards, it is a difficult matter to form a separate judgment. I am sure the general public would look with suspicion on the removal of those words.

Dr. SOUTAR: I agree with Dr. Percy Smith. There is no reflection in it; there is no reason why the two doctors should not consult, but what they have to say is what they found at the moment by separate examination. There is no interference with the holding of a consultation at all.

The CHAIRMAN: I suppose you do not wish to press the point to a division, Dr. Langdon-Down?

Dr. LANGDON-DOWN: No.

The CHAIRMAN: I put the Report as a whole. I put it with the one or two amendments which have been passed.

Carried.

Dr. SOUTAR: Before we pass to another matter I would just like to say this Report has required a tremendous amount of skill, care, and balanced consideration, and it has received that from our Chairman, Dr. Wolseley Lewis, and from Dr. Cole. The amount of work they have done in order to bring the Report to what you see you may realise, because there were several points which arose upon which great divergence of opinion must have existed and did exist. But they have succeeded by the splendid way in which they have carried out their work in producing an unanimous Report, and I think these gentlemen deserve the thanks of the Association for what they have done.

The resolution was carried by acclamation.

Dr. WOLSELEY LEWIS: I am very much obliged to you, gentlemen, for this vote of thanks. What I am really pleased with is that you have been unanimous in adopting this Report, because it strengthens the position very much.

#### PAPER.

Dr. DAVID ORR and Lieut.-Col. Rows, R.A.M.C.: "The Interdependence of the Sympathetic and Central Nervous Systems" (illustrated by slides).

(This paper, with the discussion on it, will, we hope, appear in the April issue of the Journal.—EDS.)

The CHAIRMAN said it only remained for him to thank, in the members' name, Dr. Orr and Col. Rows for their very interesting and suggestive paper. It was hoped that the subject would be brought forward on a future occasion, when, perhaps, the results of further investigations could be brought to light.

#### NORTHERN AND MIDLAND DIVISION.

THE AUTUMN MEETING of the Northern and Midland Division was held, by the kind invitation of Col. Rows, at the Military Hospital, Maghull, near Liverpool, on Thursday, October 24th, 1918.

Lieut.-Col. R. G. Rows presided.

The following eighteen members were present: Drs. R. Eager, Major, R.A.M.C.; T. Benson Evans; E. S. Hayes Gill; Stanley A. Gill; G. Hamilton Grills; E. G. Grove; Bernard Hart; D. Hunter; R. McD. Ladell; W. F. Menzies; G. E. Mould; P. G. Mould; R. G. Rows, Lieut.-Col., R.A.M.C.; C. T. Street, Major; J. B. Tighé, Lieut.-Col., R.A.M.C.; E. W. White, Lieut.-Col., R.A.M.C.; H. Yellowlees; T. S. Adair; and twenty-nine visitors.

The Minutes of the last meeting were read and confirmed.

Reference was made to the illness of the President, Lieut.-Col. Keay, and it was proposed by Col. White, and seconded by Major Eager, that a message of sympathy be sent to him.

Dr. R. S. Macphail, Dr. Bedford Pierce and Major C. T. Street were unanimously elected to form the Divisional Committee for the ensuing year.

Several short communications were then given on the work and scope of the Hospital, with an account of the types of war neuroses as seen there. Lieut.-Col. Rows gave a general outline of the conditions, and was followed by

Major Hart, Capt. Bryce and Capt. Stewart, each of whom took up some special point and discussed it. Many new and interesting points, theoretical and otherwise, were touched upon.

A pleasant visit was made round the wards and buildings of the Hospital in the morning.

A hearty vote of thanks was accorded Col. Rows for his kind and generous hospitality.

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#### SOUTH-EASTERN DIVISION.

THE AUTUMN MEETING of the South-Eastern Division of the Medico-Psychological Association was held at 11, Chandos Street, London, W. 1, on Wednesday, October 9th, 1918.

*Present*: Drs. Archdale, Bower, Chambers, Earls, Edwards, Haynes, Hughes, Norman, Shuttleworth, Stewart, and Sergeant (Hon. Div. Sec.). Dr. Shuttleworth in the Chair.

The Minutes of the last meeting were taken as read and confirmed.

The Members standing passed a vote of condolence to Mrs. Griffith, and instructed the Secretary to write expressing the sorrow of the South-Eastern Division.

Dr. Brend was unanimously elected a Member of the Association.

It was decided to leave the date and place of the Spring Meeting, 1919, to the discretion of the Secretary.

Dr. Shuttleworth informed the meeting as to recent legislation in connection with the amendment of the Asylum Workers' Superannuation Act, and the meeting then closed.

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#### SOUTH-WESTERN DIVISION.

THE AUTUMN MEETING of the above Division was held at 17, Belmont, Bath, by the kind permission of Dr. MacBryan, on Friday, October 25th, 1918, at 2.30 p.m.

The following members were present: Drs. Aveline, MacBryan, Mary Martin, Mules, Nelis, King Turner, and Bartlett (Hon. Div. Secretary). Dr. C. E. S. Flemming was welcomed as a visitor.

Dr. Nelis was voted to the Chair.

Letters of regret for non-attendance from Drs. Macdonald and Devine were read.

The minutes of the last meeting were read and confirmed.

Dr. Bartlett was nominated as Hon. Div. Secretary.

Drs. Aveline and MacBryan were nominated as representative members of Council.

The place of the Spring Meeting was provisionally fixed as Fisherton House, Dr. King Turner having kindly extended an invitation.

An interesting discussion on the Cardiff leaflet followed, and the meeting expressed agreement with the reforms suggested therein, and viewed with favour the concerted effort to advance the treatment of mental disorders. The following recommendations were approved: (1) The establishment of clinics attached to general hospital, mental hospitals, and special institutions by local authorities for the treatment of early cases; (2) the approval of homes for borderland cases without certificate, to apply also to special institutions; (3) the extension of a system of voluntary boarders; (4) the more extensive employment of the services of the medical officers attached to mental hospitals in consultative work with medical practitioners; (5) the granting of power to medical practitioners to send cases for treatment and observation to approved institutions pending certificate.

Dr. C. E. S. Flemming expressed the difficulties experienced by general prac-

tioners in dealing with early and doubtful cases of mental disease under the following headings: (1) The stigma of certification; (2) the lack of approved homes for observation and treatment without certification; (3) the lack of facilities for obtaining expert advice; (4) the lack of facilities for general practitioners to gain expert knowledge.

#### SCOTTISH DIVISION.

A MEETING of the Scottish Division of the Medico-Psychological Association was held in the Royal College of Physicians, Queen Street, Edinburgh, on Friday, November 15th, 1918.

*Present:* Major Buchanan, Capt. Yellowlees, Lieut. Gostwyck, R.A.M.C., Drs. Carswell, Crichtlow, Easterbrook, Carlyle Johnstone, Kerr, T. C. Mackenzie, Tuach Mackenzie, Orr, Ford Robertson, and Surgeon-Commander R. B. Campbell, R.N., Divisional Secretary, Dr. T. Murray Lyon being present as guest.

Dr. Carlyle Johnstone occupied the chair.

Before taking up the ordinary business of the meeting the CHAIRMAN referred in appropriate terms to the loss which the Association had sustained since last meeting by the death of Dr. William Reid, Medical Superintendent, Aberdeen Royal Asylum. He stated that Dr. Reid was one of the oldest members of the Scottish Division, and that he had had a long association with asylum administration, having acted as Medical Superintendent of Aberdeen Royal Asylum for thirty-three years. The Chairman also referred to Dr. Reid's fine personal qualities. It was unanimously resolved that it be recorded in the minutes that the members of the Scottish Division of the Medico-Psychological Association desire to express their deep sense of the loss sustained by the death of Dr. Reid, and their sympathy with his relatives in their bereavement, and the Secretary was instructed to transmit an excerpt of the minutes to Mrs. Reid.

The minutes of the last Divisional meeting were read and approved, and the Chairman was authorised to sign them.

The SECRETARY intimated an apology from Lieut.-Col. Keay, President of the Association, who was unable to be present on account of illness. It was the unanimous wish of the Division that the Secretary should convey to the President an expression of regret on learning of the reason for his absence and best wishes for a speedy and complete recovery.

Apologies were also intimated from Drs. David Yellowlees, Oswald, Hotchkis, Skeen, Carre, McRae, Steele and Sutherland.

The Business Committee was appointed, consisting of the nominated member of Council, the two representative members of Council, Drs. Carlyle Johnstone, Maxwell Ross, and the Divisional Secretary.

Drs. J. H. Skeen and T. C. Mackenzie were nominated by the Division for the position of Representative Members of Council, and Dr. R. B. Campbell was nominated for the position of Divisional Secretary.

The following candidate after ballot was admitted to membership of the Association: Madeline Archibald, L.R.C.P. & L.R.C.S., Assistant Medical Officer, Argyll and Bute District Asylum, Lochgilphead. Proposed by Drs. Kerr, Dunlop Robertson, and R. B. Campbell.

Dr. G. M. ROBERTSON's paper on "The Freudian Interpretation of some Clinical Symptoms" was in his absence read by Dr. CARLYLE JOHNSTONE. A short discussion followed, in which several members took part.

The SECRETARY reported that the Sub-committee appointed by the Division to consider amendments to the existing lunacy laws had met that afternoon and considered the report of the English Lunacy Legislation Sub-committee, whose recommendations had already been circulated to the Members of the Association, and the Sub-committee expressed general approval of the recommendations contained in the report. After some little discussion the Secretary was instructed to inform the Secretary of the Parliamentary Committee of the Association that the Division approved of the recommendations contained in the Report of the English Lunacy Legislation Sub-committee.

A vote of thanks to the Chairman for presiding concluded the business of the meeting.



## OBITUARY.

JOHN B. CHAPIN, M.D.

In the fulness of years, in quiet retirement after more than a half century's active professional toil, amid scenes endeared to him by early years of association and work, surrounded by his children, having the admiration and love of the members of his profession, and the affectionate gratitude of unnumbered persons to whom or to whose friends he had been physician, guide, counsellor and friend, Dr. Chapin died at his home in Canandaigua, N.Y., on January 17th, 1918.

"Life's work well done,  
Life's race well run,  
Then comes rest."

These words form the opening passage in an appreciative and sympathetic obituary notice of the late Dr. Chapin in the *American Journal of Insanity* for April last from the pen of Dr. Brush. It occupies some seventeen pages of the journal, and we regret that the space at our disposal will only admit of an abstract being given of what is really an interesting memoir of a member of our specialty on the other side of the Atlantic, who was a man of exceptional talent and administrative ability, of unflagging industry, lofty aims, and sterling character; a man who was held in affectionate regard by a large circle of friends, both professional and lay, who felt his death as nothing less than a genuine personal bereavement. The notice is not merely a memoir of the man, but it also embodies a sketch, brief no doubt but illuminative, of the progress of enlightened ideas and action in America as regards the care and treatment of the insane over a period of more than half a century.

On his father's side Dr. Chapin was of Puritan ancestry, being in the eighth generation from Samuel Chapin, who was born in Paignton, Devonshire, in 1598. This Samuel Chapin was one of the founders of Springfield, Massachusetts, and is commemorated by St. Gauden's beautiful statue in that city. His father was William Chapin, a man of artistic tastes and literary ability, and with a practical knowledge of the art of steel engraving. He early became interested in the education of the blind, and made this his life-work. He was for some time Superintendent of the Institution for the Blind at Columbus, Ohio, and subsequently Principal of the Pennsylvania Institution for the Instruction of the Blind in Philadelphia. His mother was Elizabeth H. Bassett, daughter of the Rev. John Bassett, D.D., a graduate of Columbia College, and the recipient of honorary degrees from several other colleges, minister of the Reformed Churches at Albany, at Bushwick, and at Kingston, all in New York State, and was partly of French, partly of Dutch origin.

The educational opportunities at Columbus not being satisfactory young Chapin was sent to Philadelphia, and entered the North-west Grammar School there. He took the A.B. degree in Williams College, Philadelphia, in 1850, and the same year, having decided to enter the medical profession, in accordance with the custom of the time he entered the office of Dr. John A. Swett, one of the physicians to the New York Hospital, as a student of medicine. Soon afterwards he obtained a substitute internship in the hospital, and in 1852, after examination, an appointment on the house staff. During this period he had attended medical lectures at the Jefferson Medical College in Philadelphia, from which he received the degree of M.D. in 1853. In 1854 he was made House-Physician in the New York Hospital, where he had a period of very active service, cholera and typhus fever being epidemic at that time, and yellow fever more or less prevalent. In April, 1852, while an interne at the hospital, he attended the seventh annual meeting of the Association of Medical Superintendents of American Institutions for the Insane, now the American Medico-Psychological Association.

Having no predilection for private practice, when he had completed his service in the hospital, Dr. Chapin had the intention of entering the medical service of the United States Army. Just about this time Dr. John P. Gray, Medical Superintendent of the New York State Lunatic Asylum, now the State Asylum at Utica, offered him an appointment as Assistant Physician at that institution. This being in accordance with his inclinations, he accepted, and in September, 1854, entered

upon the duties of the position. He had no previous training in psychiatry, but his training in general medicine enabled him to meet and surmount any difficulties resulting therefrom. The *American Journal of Insanity* was edited and published in this asylum, being printed by the patients under competent supervision, and in its editorial conduct in connection with the medical superintendent Dr. Chapin found congenial occupation.

The condition of the insane in the county almshouses was about this time occupying the attention of superintendents of the poor, and Dr. Chapin by request took up the work of procuring data and drawing up a report on the subject, which appeared as Senate Document No. 17, January, 1856, N.Y. State Legislature. Thus began his work for the better care of the chronic insane of New York, and the removal of all insane persons from the county almshouses, which culminated in the establishment of the Willard Asylum, now the Willard State Hospital, with which his name will be for ever inseparably connected. The result of his investigations was that a Bill was introduced in the Senate in 1857 creating two additional asylums for the insane, and an asylum for the reception of insane convicts and criminals. The first provision failed owing to selfish contentions as to the location of the asylums, but a measure was passed creating an asylum for insane convicts at the State prison at Auburn.

In 1857 he resigned his position at Utica, and had an idea of starting practice in either Philadelphia or New York. When returning to Philadelphia he called on Dr. George Cook at Canandaigua, who proposed that he should join him in the conduct of Brigham Hall, a small private hospital for mental disorders which Dr. Cook had established at Canandaigua in 1856. The addition of a new wing was agreed upon, to be completed in 1860, and meantime Dr. Chapin was engaged in organising a new institution for the blind in St. Louis at his father's suggestion. This was, of course, only a temporary position, and in 1860 he resumed his professional work amongst the insane along with Dr. Cook at Canandaigua. His work and associates there were most congenial, and his mind turned there as to a pleasant haven of rest when he retired from hospital work in 1911.

After the failure in 1854 to effect any improvement in the condition of the insane in almshouses, nothing was done in this direction until in 1864 the State Medical Society inaugurated a movement on their behalf, into which Dr. Chapin heartily entered. A committee consisting of Dr. Charles A. Lee, Dr. S. D. Willard, and Dr. George Cook, in conjunction with members of the Legislature, formulated a Bill, which became law in April, 1864, directing the county judges to appoint a physician in each county to visit the almshouse and report upon its condition and that of the insane contained therein. The reports were made to Dr. Willard, Secretary of the State Society, and in April, 1865, a Bill was passed creating the new asylum, which was named the Willard Asylum in memory of Dr. Willard, who died just before its final passage. Its title was "An Act to Authorise the Establishment of a State Asylum for the Chronic Insane Poor." Sections of the law stating its purpose to remove the chronic insane from the almshouses to the new asylum, and making it mandatory to transfer and in future commit acute cases to the asylum at Utica, were mainly Dr. Chapin's own composition. He with two others were appointed Commissioners by Governor Fenton to locate and build the new asylum. This was designed on the villa system, the buildings being arranged in detached groups located convenient to the gardens and farm-barns, where the patients would be near the work in which they might be engaged. This was a radical departure from existing methods, and met with the usual adverse criticism. The plans also provided for an administration building with a main hospital group attached. For these Dr. Chapin was wholly responsible, and under his direction the buildings were located and completed, and for the first time in this country an institution was established with a thoroughly elastic plan, with a segregation rather than an aggregation of buildings, and with the distinct purpose in view of facilitating the occupation of patients upon the farm, and in other ways to aid in their own support. This was really the beginning of State care in New York. The principle of State care was engrafted in the Willard Act. It was intended to take and thereafter keep from county almshouses the insane poor.

The first Board of Trustees appointed under the Act elected Dr. Chapin medical superintendent of the new asylum—a position he had not sought or desired; nor did he accept it until after three months' consideration, when he did so on the

condition that the service was to continue during the period of organisation only, and not longer than three years. This, however, he did not adhere to, and remained in charge until 1884, when he was called to succeed Dr. Kirkbride at the Department for the Insane of the Pennsylvania Hospital, Philadelphia. The invitation was twice declined; the roots had struck deep in Willard—there was a disinclination to abandon a work to which for many and obvious reasons he was deeply attached—but finally he became convinced that it was his duty to accept, and in September, 1884, he entered upon a service in Philadelphia which continued for twenty-seven years. He had at that time reached the age of fifty-five, was still active, and by no means lacking in enthusiasm and initiative.

Shortly after going to Philadelphia a fire occurred in the insane department of Blockley, the city almshouse and hospital. Several insane patients lost their lives, and much property damage was incurred. Blockley Asylum had long been condemned as a place for detention for the insane, and after the fire Dr. Chapin and Dr. Brush were asked to confer with the Board of Guardians of the Poor as to the best course to follow. At that conference Dr. Chapin outlined a plan which, if followed, would have given Philadelphia the honour of establishing the first psychiatric clinic in the United States. He pointed out to the Board the real situation, showing them that Blockley was badly overcrowded, that there were no adequate means of exercise in the open air, no provision for occupation, no proper nursing, and not sufficient medical care and supervision. He called attention to the very large annual admission-rate, small recovery-rate, and a large death-rate. He then dwelt on the need of training in psychiatry for young men, which then in this country in medical schools was wholly lacking, and the excellent opportunities at Blockley for the medical schools of the city. He said:

"Establish here a small hospital of from 100 to 200 beds, to which all cases coming under city care shall be sent at once. Concentrate here the medical work, to be done by a large, resident staff under a competent chief. Establish laboratories and all the requisites of a good hospital, and use the material for clinical instruction. A certain proportion of the cases admitted will need but a few weeks' care here, many others longer care, and many permanent care. Establish therefore in the country a colony farm, with its hospital, medical, and nursing staff, and its groups for permanent cases, who should be employed on the farm and in shops, and contribute to their own support."

We have given here but a hasty outline of a lengthy conference, but it can be seen what an excellent scheme was laid before the Board, only, alas, to be rejected as too expensive! The burned wards were rebuilt, and the old routine went on, to the everlasting disgrace of the city of "Brotherly Love."

Dr. Chapin received the honorary degree of LL.D. from Jefferson College, Pennsylvania, and from his *alma mater*, Williams College. He was a Fellow of the College of Physicians of Philadelphia, and an honorary member of the Medico-Psychological Association of Great Britain and Ireland and the Société de Médecine Mentale de Belgique.

On December 1st, 1904, he was given a complimentary dinner at the Bellevue-Stratford Hotel in Philadelphia, which was very largely attended, and which marked the completion of fifty years' work in hospitals for the insane. On this occasion he was presented with a life-size portrait of himself. He had at this time exceeded the Psalmist's limit of three score years and ten, and had more than once brought before the managers of the hospital the question of laying down his office; but it was the desire of the Board that he should continue at his post, and so for seven years longer he remained at the hospital in West Philadelphia, resigning and moving to a home which he had prepared in Canandaigua in the summer of 1911. His last attendance at a meeting of the Association was in 1913 at Niagara Falls, when he showed but little of the physical weakness of age and no perceptible diminution of his mental vigour. [In this feature of the maintenance of freshness and power of intellect a not unworthy comparison may be drawn between him and our own countryman, the late Dr. Henry Maudsley, who died within a week after Dr. Chapin's decease.—Eps. J.M.S.]

In 1858 he had married Miss Harriet E. Preston, and in her death in the summer of 1916 he met the greatest grief of his life, after more than fifty-eight years of the most intimate and loving association. After her departure he seemed more or less dazed. He could not adjust himself to the changed conditions—he had lost not

only his occupation in looking after her every wish, but he had lost his bearings in a measure.

His home life was made as cheerful as possible by the continued presence in turn of one of his three daughters. He went about the streets of the beautiful old town when the weather permitted. A day or two before his death he went down town with his daughter, and shortly after returning home complained of feeling ill. When a physician was sent for he said it was unnecessary, as he knew what was the matter—it was the breaking down at the end, and so it proved to be. He retained his old jocular manner almost to the close. His medical adviser called in a consultant, and together they gave their patient a thorough physical examination. As they went from the sick room to confer he remarked, "They'll go down stairs and give my disorder a name, but that will not change the result." The end came rapidly, with fortunately little suffering, and on the afternoon of Thursday, January 17th, 1918, in his eighty-ninth year, "in the comfort of a reasonable religious and holy hope," he fell asleep.

Dr. Chapin's great force arose from his self-control and his careful preparation for the work before him, which led him to study every problem presented with a feeling, as he expressed it, that the knowledge obtained would become available "somewhere, at some time." He was a man of most straightforward character, with no suspicion of indirectness in his methods. Of deep religious convictions, he carried his religion into his daily life, and made it a religion of service to God and his fellow men. In this he exemplified Whittier's dictum, "He who blesses most is blest."

As a great administrator, as a far-seeing philanthropist who accomplished more for his fellow men than can now be estimated, as a conscientious and well-trained physician, he has set his mark upon the history of his country and his profession.

"Servant of God, well done; well hast thou fought  
The better fight."

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ALFRED HUME GRIFFITH, M.D.Edin., D.P.H.Camb.

*Superintendent and Medical Officer of Lingfield Colony for Epileptics, Surrey.*

ALTHOUGH Dr. Alfred Hume Griffith was but a comparatively recent member of our Association, his many activities and his manifest zeal for the welfare of others demand that his premature death—which occurred on September 24th, and by which the medical profession has lost a member of the type it can most ill spare—should receive something more than its record in our obituary list. The second son of the late Reverend Edward Moule Griffith (B.A.Cantab.), he was born in Worcestershire in 1875, and received his preliminary education at Persse School, Cambridge, and at Totnes and Bedford Grammar Schools. The spirit of altruism and of the missionary—in the best sense of that word—strongly characterised even the earlier years of his manhood, and it was in order to fit himself in what seemed to him the best possible manner to be of service to others, and not at all from its lucrative possibilities, that he decided to enter the medical profession. With this intent he matriculated at Edinburgh in 1893, and graduated in Medicine in 1899. In the following year he married Mary, daughter of George Welchman, of Cul-lompton, and immediately thereafter they went out to Persia in order that he might take temporary charge of the medical mission work at Ispahan. In 1901 he was appointed to undertake pioneer work in Kerman, and it was there—during a year of strenuous work, reluctantly relinquished on account of his wife's ill-health—that by his personal influence and by the magnetic force of his character, fortified with his medical training, he was so successful in breaking down much opposition and hostile fanaticism—dangers which, in similar circumstances, have all too often cost the lives of those determined to face them. During part of 1902 and of the following year he assumed charge of the medical mission work at Gaza, and finally left Persia in 1903. After a short furlough, largely spent in study at Edinburgh and during which time he took his M.D. degree, Griffith offered himself for work in Palestine; he was appointed to the C.M.S. hospital at Nablus, and while pro-



ceeding thither he obtained at Constantinople the Turkish certificate, enabling him to practise medicine throughout the Turkish empire. In 1904, after a year's residence at Nablus, he moved to Mosul in Mesopotamia, where for four years he lived a life of noble self-sacrifice and devotion to the needs of those about him. He founded a hospital, where, in the absence of the aid of any European doctor or nurse, and assisted only by native men whom he himself had trained, he performed an extensive amount of surgical work, including many major operations and numerous operations for cataract and lithotomies. His collection of calculi is in the museum at Cambridge. But his unfailing obedience to the ceaseless calls on his time and strength proved too great a strain on his health, and, to his deep disappointment, he had to submit in 1908 to being invalided home.

It was in October, 1910, after a period of further study, during which he obtained the Cambridge D.P.H., that Griffith was appointed Superintendent and Medical Officer of Lingfield Colony for Epileptics—one of the several homes established by the National Union for Christian Social Service, and an institution the deservedly high reputation of which he has done so much to enhance. If his impaired health compelled him to confine his energies within a comparatively restricted sphere, he none the less threw them heartily into his new work, and he was able to bring to it a rare union of qualities best suited for the successful handling and treatment in colony life of a malady and temperament admittedly presenting peculiar difficulties. Himself of athletic instincts—he was an Edinburgh "blue" in football, and when abroad never so happy as in the saddle—he saw to it that his patients as far as possible lived an open-air life, abundantly supplied with occupation, recreation, and hobbies. Nevertheless, he was an omnivorous reader, and kept himself well abreast with the results of medical research, especially those which he could use to his patients' advantage. His own powers of observation and research are displayed in the contributions he made to medical and other literature, among which mention may be made of "Hereditary Factors in Epilepsy" (*Review of Neurology and Psychiatry*, 1911), "Cerebellar Abscess" (*Scottish Medical and Surgical Journal*, 1904), "Lingfield Epileptic Colony" (*The Child*, 1911), "Mental Tests in Defective Children" (*The Child*, 1916), "The Epileptic" (a chapter in Kelyack's *Human Derelicts*), and some chapters on medical missions in his wife's book, *Behind the Veil in Persia and Turkish Arabia*.

On intimation being made that the Ministry of Pensions were in pressing need of further accommodation for the institutional treatment and training of discharged sailors and soldiers suffering from epilepsy, and that through the British Red Cross Society initial funds would be available to meet capital expenditure, Griffith, with the assent and co-operation of his Committee and despite his precarious health, readily agreed to meet these needs so far as the possibilities at Lingfield permitted. Experience has shown that the satisfactory treatment of these particular cases is a specially difficult problem: so many of the men fail to realise their disability, and are, not unnaturally, impatient of the necessarily prolonged treatment. But Griffith knew his men; he possessed the technical skill requisite to obtain insight into their individual peculiarities and often into the origin of the latter, and his sympathy with them and determination to restore them to a normal civilian life engendered, besides affection, a loyalty to *régime* that explains much of his success. He had many projects in view for the development of the Lingfield Colony's sphere of usefulness, and the carrying of these into effect will be the best tribute to his memory.

Besides his patients, staff, and many friends, he leaves to mourn his loss his widow and a young daughter, the former of whom has been his indefatigable companion and collaborator, and to whom, throughout the ten painful weeks of his fatal illness, he made no murmur of complaint. He was buried in Lingfield Churchyard.

C. H. B.

#### CAPT. ERNEST FRYER BALLARD, R.A.M.C.

It is with very deep regret that we have to record the death of Capt. Ernest Fryer Ballard, R.A.M.C., at the early age of thirty-three, from influenza and pneumonia, which took place at Brighton on October 23rd last.

Capt. Ballard received his education at the Merchant Tailors' School and at St. Thomas's Hospital, where he won a scholarship. After graduating M.B., B.S., at London University, he for upwards of four years was Assistant Medical Officer at the Somerset and Bath Asylum at Wells. He was never robust, and, his health breaking down, he returned to his home at Brighton, where for some time he was House-Surgeon to the Throat and Ear Hospital. He joined the Army in June, 1915, and, being in a very low category, he was given home service, and was attached to the 2nd Eastern General Hospital. The experience he had gained in mental disease led to his being posted to the Portland Road Section of the 2nd Eastern, which was devoted to the care and treatment of soldiers suffering from nervous and incipient mental conditions. He was deeply attached to the mental aspect of the work, and although he had ceased to be actively connected with this sphere of medicine for some time previous to entering the Army, he yet continued to interest himself in modern psychiatry, and particularly in psycho-analysis. He retained his membership of the Association and attended the meetings when opportunity offered. He contributed articles to the Journal—in fact his last article appeared in the October issue—and he published an *Epitome of Mental Disorders*, which is a useful introduction for students. He had a most agreeable personality, was an indefatigable worker, and did not spare himself in the interests of his patients.

The funeral took place at Brighton, the special service held in the Chapel of the 2nd Eastern General Hospital being attended by a large number of senior officers and staff and also patients.

By the death of Capt. Ballard the Association has lost a very charming and accomplished member, and we tender to his family an expression of our sympathy and regret.

Capt. Ballard was passionately fond of cricket and football, but his indifferent health prevented him taking as active a part in these games as he wished. He was a keen botanist and entomologist, but his chief interest lay in his home life, devoting himself to the happiness of his parents. His brain was ever at work—always reading to acquire knowledge. Although not making much outward show, he was deeply religious, and took great pleasure in reconciling his scientific knowledge with the truths taught in Scripture.

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#### THOMAS HERBERT, M.R.C.S., L.R.C.P.Lond.

WE regret to hear of the death on October 23rd, 1918, of Dr. Thomas Herbert, late Senior Assistant Medical Officer in York City Asylum, Fulford. Dr. Hopkins, Medical Superintendent of this Asylum, writes of Dr. Herbert as follows:

"Dr. Herbert had been the Assistant Medical Officer at this Asylum since its opening in March, 1906—a period of 12½ years. He left here on holiday on October 18th, and whilst on a visit to his brother-in-law in Cardiff was found dead in bed on the morning of October 23rd. The cause of death was given as valvular disease of the heart. He had not been well previous to being here, but I did not know of the existence of any heart disease, so that his death was entirely unexpected.

"I can say that he was greatly respected by the staff and patients, by whom his loss was much felt, as well as by myself, to whom he was a great assistance and an agreeable colleague."

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#### NOTICES BY REGISTRAR.

##### *Nursing Examinations.*

Preliminary . . . . . Monday, May 5th, 1919.

Final . . . . . Monday, May 12th, 1919.

Papers for Bronze Medal must reach Registrar prior to June 20th.

The Examinations for Certificate in Psychological Medicine and Gaskell Prize will be held early in July.

For particulars apply to Registrar, Dr. A. Miller, Hatton, Warwick.

Publication of results of November Examinations has to be deferred until our April issue.

## NOTICE TO CONTRIBUTORS.

*N.B.*—The Editors will be glad to receive contributions of interest, clinical records, etc., from any members who can find time to write (whether these have been read at meetings or not) for publication in the Journal. They will also feel obliged if contributors will send in their papers at as early a date in each quarter as possible.

Writers are requested kindly to bear in mind that, according to LIX(a) of the Articles of Association, "all papers read at the Annual, General, or Divisional Meetings of the Association shall be the property of the Association, unless the author shall have previously obtained the written consent of the Editors to the contrary."

*Papers read at Association Meetings should, therefore, not be published in other Journals without such sanction having been previously granted.*

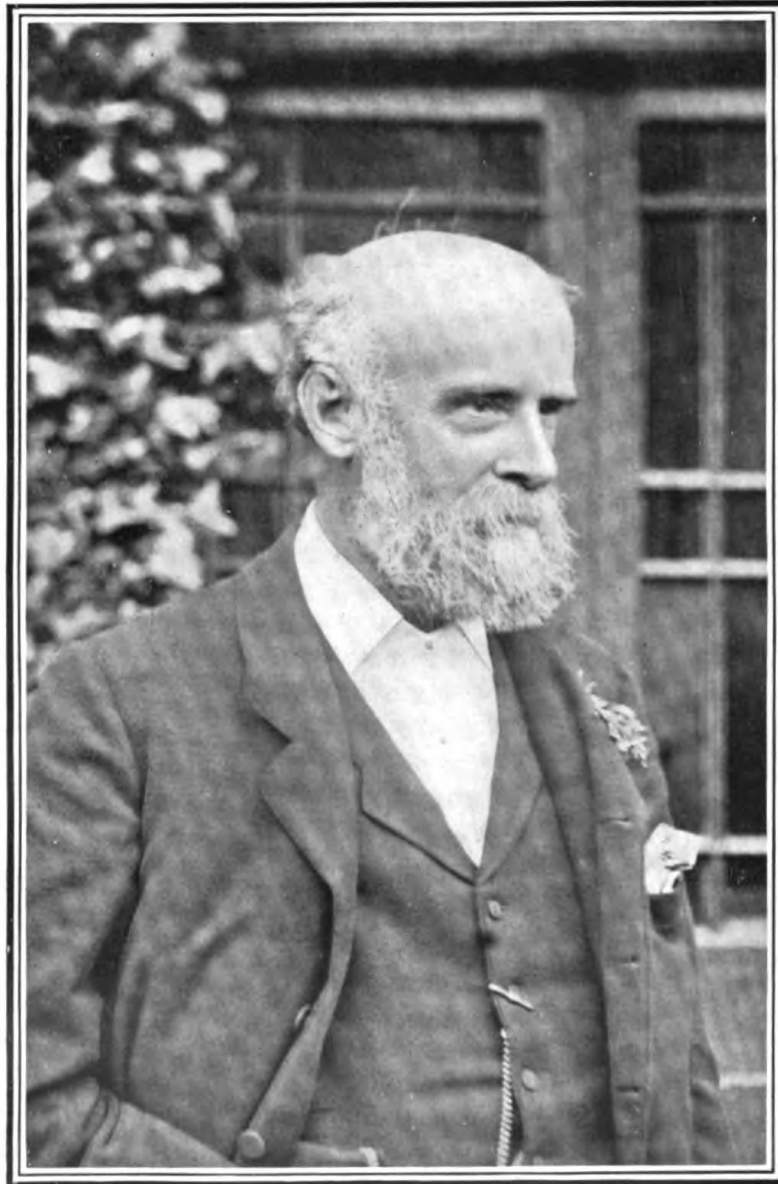
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The Editors regret that the Journal has to be reduced in size to such a large extent. They have received instructions that, owing to the exigences of existing circumstances, scarcity of paper, increased cost of production, etc., its dimensions on this occasion must not exceed 64 pages, exclusive of List of Members. They have therefore been obliged to postpone the publication of a good deal of the material in hand, and already printed, to a future issue. Writers of papers which have thus to be withheld for the present will kindly accept this notice as explanation.









GEORGE WILLIAM MOULD, M.R.C.S.

Obiit January 14th, 1919.

President, 1830.

*Adlard & Son & West Newman, Ltd.*

THE  
JOURNAL OF MENTAL SCIENCE

[Published by Authority of the Medico-Psychological Association  
of Great Britain and Ireland.]

No. 269 [NEW SERIES  
No. 233.]

APRIL, 1919.

VOL. LXV.

Part I.—Original Articles.

*War Psychology: English and German.* By the late  
Dr. HENRY MAUDSLEY.

[THE following article was sent to the Editors so far back as the autumn of 1916. Exception was taken by the Censor to certain passages, and as it was felt that it was preferable that it should be published in its entirety or not at all, its publication was withheld in the hope that the objections would eventually be withdrawn. This has now been done, and the Editors are glad to be in a position to present the article as it came from the pen of Dr. Maudsley, and without any mutilation.

It is not to be expected that everyone will agree with the views of the writer, but there is little doubt that the paper will be read with interest coming from such a source, written as it was shortly before the termination of his career, and constituting one of the latest utterances of a great thinker, whose writings have always been infused with a truly scientific spirit, and characterised by a dispassionate philosophy expounded with almost judicial fairness, and rare literary genius maintained to practically the close of a life prolonged far beyond the average. The whole article embodies a quasi-prophetic warning, delivered at a time when the nations were in the convulsive throes of a world-wide conflict, from the bitter aftermath of which we are scarcely as yet emancipated: a warning which, if somewhat pessimistic in tone, may be, perhaps, not altogether unheeded, as the outlook is still full of uncertainty, and as there is at least a possibility that our roseate anticipations of a Golden

Age, a millennium of peace on earth, and universal mutual goodwill among all nations, may fail to reach its long wished for fulfilment.]

To understand truly the psychology of the nations which have plunged headlong into the present unprecedented war, it is incumbent not only to study their elaborate historical records but to take a deeper biological account of the native vigour of each national stock. Mind being fundamentally life in mind, and life being essentially motion, its manifestations presuppose and disclose the vigour of its native vital force. For that reason the psychology which concerns itself only with conscious display must needs be wanting in depth and hold of reality. Is the Teutonic race perchance superior in vital vigour, as it believes, and the Latin races comparatively weak and decadent ; its present outburst of military force therefore just the natural consequence of its stronger vitality ?

The universal characteristic of life notably is its amazing productiveness and unceasing impulse to prolific increase from the moment when it comes into being in its simplest vital plasm. A continual destruction immensely disproportionate to survival is the consequence : in the order and purpose of Nature death as normal a factor as life, although conscious life is loth to think it as natural and necessary. In this perpetual vital propulsion stronger life survives and grows at the cost of weaker life, building up higher vital complexes in ascending scale by feeding on lower vital complexes. Thence the so-called struggle for existence and survival of the fittest ; which is a fundamental fact of the procession of Nature from age to age. Such ethical considerations as right, justice, pity, mercy, have no part or place on that low plane of vital energy which will withal, be it understood, not fail to continue to operate actively even after they come into being and application on a higher plane of human development. This is an important fact which the enthusiastic humanitarian, shrouding reality in a haze of incontinent sentiment, is apt to lose sight of in his optimistic expectation of a complete moral regeneration of humanity after the war is over.

Whence in the system of Nature is life's immanent impulse to increase derived ? Without doubt immediately from the



perpetual heat of the sun's rays on the vital plasm to which it owed its origin, and by which it is sustained in being : vital force, no self-sufficing and self-determining fictitious entity as commonly supposed, but a natural continuity and complex of unified material forces, its impulsion fundamentally propulsion. Remotely, of course, from the ultimate supreme reality of the universe which, being incomprehensible and ineffable, cannot be expressed in terms of human thought. Certain it is that the one universal dynamic energy unknown and unknowable, however named, comes from above and is distributed downwards in countless channels through every grade of being—through stars and suns, grass and flowers, insects and birds, beasts and men. That is the plain conclusion of physical science beyond which it cannot and forbears to go.

Such stay of thought is unwelcome to human feeling. Hence the postulate of the Divine source ascribed to it by imagination urged by feeling to transcend in its flight the narrow limitations of thought.<sup>(1)</sup> Construing the illimitable universe in terms of his limited experience and understanding, man is impelled to postulate and personalize a Supreme Being as the ultimate reality and source whence all things proceed, and thereupon to fashion it more or less in the image of his ideal self. That is to say, when he has risen to the conception of unity, and got quit of the effete notions of the various inferior gods which he was compelled to imagine in his slow and irregular ascent of thought to that height. Proceeding from that conception of a one true God, and imbued with the social feeling of the higher vital complex which he has reached in his ascending organization, he naturally finds the Divine in all the phenomena and processes of the visible world, and, above all, specially and supremely incarnate at last in the person of Jesus of Nazareth, who was therefore God and man. Thenceforth he can look hopefully forward to a fatherhood of God and final brotherhood of mankind through worship of that divine Mediator, notwithstanding the disheartening events which, like the present war, occur to perplex and confound him—until, that is, he has divined their regenerative purpose.

Here, it is true, thought is brought into contact with two apparently antagonistic forces. On the one hand is the fundamental self-regarding force of prolific life ever pressing onward to expand beneath all conscious manifestations, and on the

other hand is the social or moral ideal of an altruistic suppression of individual vital force to serve the construction of a higher vital complex, and therewith the future development of humanity. The question of paramount importance obviously is, Which shall prevail in the end, the crude vital force or a progressive incarnation of the Divine in human nature? Now it is certain that the vital force cannot abate its essential impulsion and stay its natural self-regarding energy so long as the sun's rays continue to beat upon its vital plasm with unabated energy. But it is nowise incredible, on the contrary quite conceivable, that its force shall, in the human sphere, be minutely divided, regulated, refined, and absorbed into a progressive social and moral development of the race, and that be accomplished in reality which is yet a pious aspiration in the abstract. Therein lie the hope and promise of an indefinite human progress in time to come.

Is the abstract ideal then destined to be realized at last? Or is it possibly only an illusion, nothing more than the effect and expression in consciousness of the underlying perpetual vital push of the incorporate sun's rays? Can it justly be assumed to be prophetic of things to come? Mankind have always needed and progressed by means of the illusions and fictions which they created to inspire and spur them in their successive developmental ascents, and have abandoned them one after another when they were no longer serviceable. In all times and places the unfailing vital energy has thus enshrined itself in fitting fictions of thought, as it will no doubt continue to do while it lasts in full vigour. That life will live and grow for ever on earth is without doubt an illusion. End it must when the sun is "turned into darkness." But that is an event so remote that present life need not concern itself with it. How, indeed, can relative life, which is propelled motion, possibly realise absolute motionlessness? Meanwhile, within the immeasurable time of its continuance, it is instinct with the implicit conviction of a progressive ascent to higher vital complexity. The history of its past rise from lower to higher vital complexes justifies the hope and patient expectation of a continuance of the process of organic ascent, and therewith the faith in its progress along a moral line of evolution. Even from the scientific point of view, therefore, the opinion that the crude struggle for material existence will be superseded by a struggle

for higher moral existence is not unwarranted. Higher vital complexes shall presumably be gradually organized, in whose structure the crude vital force is divided, regulated, refined, and condensed. Not otherwise, in fact, than as in the formation of living protoplasm the simpler physico-chemical forces have been controlled, regulated, and combined in its complex structure, and are constantly thus subtilized and combined in the secret operations and processes of the bodily metabolism. The process of moral ascent will be simply a continuance of the process of organic evolution which has gone on from the beginning of life, and the survival of the fittest be a survival not of the strongest in a merely physical struggle to live, naturally indifferent then to all moral considerations, but of the fittest in a natural evolution making for social advancement and righteousness on earth. International immorality, concerned only with the victory of might and guile, may be expected then to prove as unfitting and disastrous as intra-national immorality would be in a particular nation which should adopt that pernicious practice. That the motions of the two apparently antagonistic forces shall thus be harmonized and combined in a higher vital unity, and the self-regarding vital force merge its absorbed energy in refined forces of altruistic evolution; such is the pleasing hope and pious aspiration.

Assuredly the present murderous war has been a rude shock to such idealistic expectation. After nearly two thousand years of Christian profession, the most civilized specimens of the race have found no better use of their gains than to plunge into the biggest, bloodiest, and most destructive war in human history, and to prosecute it with all the most devastating means of destruction which their conquests and control of the forces of Nature have enabled them to devise and employ. All the long and laboriously accumulated acquisitions of human intellect through the ages have been applied with the utmost ingenuity and fiercest resolution to purposes of self-destruction. Such is the result which Nature, operating through its human nature, has brought about as necessary effect in the proper course of its system of evolution. Had any gifted seer a month before the unforeseen eruption of brute vital passions in floods of devastation been bold enough to predict the inevitable catastrophe he would certainly have been denounced as a madman,

or scouted as a despicable and anti-human disbeliever in the value of Christianity and the progress of humanity, if any notice had been taken of him at all. Yet it ought to have been foreseen by beings so proud of their present height of intellectual development, and might perhaps have been predicted by a sufficiently cool, penetrating, and prescient student of history. Frederick the Great, as deliberate and resolute an embodiment of treacherous, unscrupulous, and successful brutality as the world is perhaps ever likely to see and enthrone in its admiration (his successful fraud and force having enshrined him as 'The Great'), is the ideal monarch of North Germany, and its present ruler Wilhelm II, its 'All Highest,' and 'Supreme War Lord.' What then has naturally and necessarily happened? That the brute force of vigorous life has asserted and mercilessly executed itself in open and deliberate defiance of the gentle growth of a slowly progressive humanity, and, were it to prove successful, might gloriously enshrine a Wilhelm the Great or Greater—at any rate in Germany. That is the real fact to be faced by an optimistic idealism, a fact the significance of which cannot be got rid of, as the manner is, by putting on an extra strain of sentimental idealism to hide it.

Moreover, in frankly facing the disagreeable fact, it is proper to bear in mind that the fighting nations are alike sincere in their belief that they are fighting for the right and the promotion of a true human development. It is absurd for one nation to assume that the enemy is purely hypocritical, as it might indeed perceive and own were it to try to see itself as the other sees and its own history reveals it, which is truly revealed in the nation, as in the individual, not by its words, but by its deeds. But how can Germany, it is asked, really believe that it acted rightly in its unprovoked attack on nations which wished only to be left at peace, and in treacherously preparing for years—steadily, secretly, and systematically—the means of such a sudden and unexpected attack when the opportune moment arrived? But Germany does not for an instant admit that the attack was unprovoked and unjustifiable. Looking farther back than the immediate precedent circumstances, it found sufficient provocation there, and concluded an immediate attack to be the sensible and righteous defence.<sup>(2)</sup> A strong, virile and expanding nation perceived itself sur-



rounded by secretly hostile nations in tacit league to bar its needed outlets of expansion and deliberately resolved to obtain them. Having made a modest attempt in Morocco to find a place in the sun—nominally, but really a most formidable post and war station—when the French were taking possession of that country, it was met with the threat of a determined opposition in which the French relied upon the support of England, and presumably of Russia. Yet France was then aggressively extending its colonial dominion, although by deliberate and systematic restriction of its families at home it was not producing sufficient children to keep up its own population. What else could a vigorously vital nation with a superabundant population do but patiently watch and wait until it had perfected the means of breaking down the envying opposition? Vital force in the life plasm would not be vital if it suppressed itself, or allowed itself to be suppressed by its environment. Futile discussion as to whether Germany started the war is no better than puerile pedantry concerning itself with words on the part of shallow-minded diplomatists who, blind to the real forces at work, did not foresee its certain and immediate outbreak—although such foresight was the reason of their being—and persuaded themselves that they could prevent it by words.

The Allies on their side are, no doubt, sincerely convinced, as they hearten themselves by protesting, that they are fighting for right and justice and the cause of true civilization. Yet the Germans, who believe themselves to be good Christians, are passionately convinced that their cause is just, join wholeheartedly in prayer to God for its triumph, and rightly deride the ridiculous notion that the whole nation is a docile people, enslaved by a few domineering Prussians from whose yoke it would wish and welcome deliverance. That is the foolish opinion of persons who did not foresee the impending and inevitable storm, but contemptuously scouted the urgent warnings of those who strove in vain to awaken them to the portentous signs. If such deliverance is to come, sound reason teaches that it must come gradually from a change of mind within the nation. A nation cannot change its constitutional habit of thought and feeling at the bidding of other differently constituted nations. As well ask the lily to blossom like the rose.



The Germans are not merely the thoroughly practical people which they have proved themselves to be in industrial, scientific, and military organization, but are essentially a nation of idealists. They have not lost the idealistic spirit which showed itself so eminently in their philosophers—in Fichte, Schelling, Hegel, and many less distinguished thinkers—but have turned and applied it systematically to material and scientific uses. They still conceive theories, and having conceived a theory, philosophic or scientific, make it a creed for the time, thereupon prosecuting it by patient and systematically organized trial either to success and acceptance or to failure and abandonment. In every branch of knowledge, in theology, philosophy, history, and science that is their habit of mind. And the theory which they have now formed is that they embody the highest culture in the world and are justified in spreading it for the advancement of humanity. Arrogant as the assumption seems now in its naked crudity, the theory would not have seemed so outrageous before the war when it was being quietly assumed, peacefully prosecuted, and indeed generally accepted in England and America by writers who industriously provided for their pupils hashes of German philosophy in their Universities, and greedily sucked in the latest German scientific theories by whomsoever and wheresoever propounded in Germany. Like the Jews of old, the Germans claim to be a chosen people and, like them, ordained to fulfil the Divine Will. Monstrous as the claim now appears on its bare face, it ought not justly to shock and revolt Christians who accept the theory that the Jews were a chosen people, and glorify Christianity as the Divine evolution of Judaism.

The wonder and the pity of it is that, while hugging the creed, the Germans, like the Jews of old, should have sincerely convinced themselves that they were divinely ordained to accomplish their mission by unscrupulous treachery, systematic devastation, and ruthless butcheries of men, women, and children, in fact by systematically practising with German thoroughness a rule of infamous "frightfulness," and that they should now with German thoroughness justify their deliberately practised terrorism as the right means to enforce a speedier submission, and ensure German dominion on earth. Yet this theory showed no new spirit in them, was no exceptional ebullition of brutality; it was the natural expression of the

Prussian brutal nature. Their Emperor, in his memorable address to his troops about to depart to China to suppress the Boxer rising, sternly adjured them to rival the frightfulness of the Huns. And his troops faithfully obeyed his injunctions, ruthlessly shooting harmless women and children who flocked into a street, out of curiosity to see them pass, and thereafter justifying and triumphing in their uncensured butchery—silently condoned indeed by its then allies and present enemies. To their military subordinated minds their Supreme War Lord, their All Highest, was the chosen instrument in the ordained progress of the human race, as he apparently sincerely believes himself to be. Ingrained in the German nature are docile service to the State and its military organisation as the habit of life, and unquestioning obedience to the Head of it; all sense of individual responsibility swallowed up in adoration of the 'All Highest' himself, in sure alliance with the Most High as he has persistently claimed to be, and has apparently infused into them.<sup>(3)</sup> Withal they conform to the inspired Jewish teachings of the Old Testament, which were practically efficient and fulfilled the Divine Will before the New Testament came into being with a new order of precepts, which are yet only ideal and confessedly impracticable between States in the actual world. The profession of them by those who do not and cannot practise them they naturally count hypocrisy and despise as inefficiency.

But is not that, it will be asked, to throw Christianity clean overboard? No! is the confident answer even of their divines, it is only to restrict it to its proper sphere at the present level of civilization in the Divine procession of events. The morality between State and State cannot possibly for a long time to come be the morality of the Sermon on the Mount. Indeed, it never was nor ever could have been the morality of any State; for no State could have been built and kept up on the foundation of such principles, nor any State continue to exist which practised them. In things which belong to the domain of the construction and maintenance of the State it has always been necessary to discriminate between spiritual and worldly matters. The State has grown up by the will and force to make weaker peoples subservient to it, and will continue naturally to do so. And inasmuch as in the progress of human development the manifest impulse of the vital force is

to the formation of more and more complex social bodies, and to its embodiment in the State as the supreme social complex it necessarily follows that the strongest vital force will embody itself in the strongest State. When the superior State, pre-eminent in vital strength and intellectual culture, has perfected itself and fulfilled its mission, then shall come the time when it can rightly be impregnated with, and apply ethical principles in its dealings with subjugated peoples. Meanwhile, it needs and must use more force than justice, more pitilessness than pity, more rigour than mercy. International morality is the possibility and ideal of the future, when humanity has risen to that height of development. That is the German theory which is now being systematically tried in practice with German thoroughness.

It is withal the logical application in practice of German philosophy, the effect of which, good or bad, remains to be seen. A fair summary of Hegel's philosophic teaching would seem to be much as follows: The great State is built up by war, by conquests, by annexation, by subjugation of weaker peoples. It stands for an idea, a grand beneficent civilizing idea, pregnant and prophetic, and is in duty bound to conquer and annex small States. But, as every State will naturally take it for granted that its own idea is the best, the best can only be distinguished by victory. It is victory which proves that the victor is not only stronger materially, but, standing for a nobler and more vital idea, is the mark of a moral superiority. War is a necessary condition of the evolution of humanity, and generations to come will witness a succession of the triumphs of vital force—for the triumph in fact of the prophetic idea which contains the future over an idea out of date, senile and decadent. Germany, therefore, thus instructed, cares nothing for accusations of infamous barbarity in its conduct of war; they do not touch its conscience; they are not applicable to civilization at its present transitional level. War is war, intrinsically conscienceless, and must be waged relentlessly. Every act which is done to discourage, defeat, and destroy its enemies is a brave and justifiable deed. Victory must be won; nothing else matters. And when it is won, it will be a proof of moral as well as material superiority, being then the fulfilment of the Divine Will.

It is a theory which does not commend itself to the British

mind. Yet it is what the stronger British race has constantly approved and practised in its subjugation of weaker and so-called inferior races—in India, in Egypt, in New Zealand, in every part of the earth where it has enforced and established its vast dominion. The benefits which it has conferred on the subjugated peoples by raising them a step in its type of civilization (which Ruskin describes as “in many respects one of the most horrible types of society that has ever existed in the world’s history”) it counts a justification of the servitude which it has imposed upon them. And it is now unsparing in its expenditure of missionary zeal and money to inculcate by the propagation of the Gospel the Christian doctrines and principles which it systematically disregarded and defied in taking possession of their countries for commercial and military purposes. Why then is it so grievously shocked at the proposed application to itself of similar methods by the Germans, who deem themselves similarly justified by their racial and mental superiority, and intend, like it, to bring Christian principles into use when they have established the supremacy of their sounder and more vigorous vitality and higher intellectual culture? British expansion, when all is said, was really the crude effect and expression of rude vital force, the sequent moral justifications having been the embellishing after-thoughts.

It is a characteristic and perhaps an advantage of the British practical mind that it is not idealistic nor severely logical, nor anywise disturbed by inconsistencies of thought. Life has its logic deeper than thought to which thought in the sequence adjusts itself. It believes that it can somehow combine spiritual and worldly matters in the international relations of life, and thinks to do so; its so-called cant and hypocrisy a practical testimony to the immanent ideal, the expression of a pious wish for what it wishes should be. Yet, as such combination is not really possible in practice, and would be as disastrous to a State as it would be for an individual in a particular nation when someone steals his cloak to give him coat also, the attempted compromise is necessarily disadvantageous; it incurs the immediate danger of ineffective practice, as well as provokes the natural accusation of cant and hypocrisy. In a deadly war between two nations the one which uses every means it can to conquer will have an



advantage over the enemy which compromises between right and wrong means ; the result necessarily a simple matter of pure vital force struggling to maintain and expand itself. A brutal and horrible struggle, it is true, but inevitable: just a repetition of what has been hitherto in the procession of human events. If war be wicked, though it has hitherto been the efficient and divinely ordained factor in the evolution of the human drama through the ages, the impious conclusion would follow that the world has been wickedly governed ; which is as absurd a banishment of the spiritual from the government of the Universe as it would be to introduce the spiritual freely into the method of actually conducting a war in an international life-and-death fight. Even Luther, who believed his native brutality to be Christianized—though it never was—stoutly affirmed the necessity of separating the spiritual from the real in war and other worldly matters. And Christian pastors in Germany now openly defend the doctrine which Christians outside Germany are forced implicitly to acknowledge and actually to practise, though loth explicitly to confess, the elimination of the ethical conscience from conduct even in unethical war.

The habit of the English mind is to treat conscience as something sacred in the abstract without considering at all what it actually is in the concrete. To it conscience is a divinely implanted something in every individual mind which ought always to be respected as sacred. That is really to delude itself with words without thinking in the least what they mean. For what is conscience, sincerely considered as a reality, not abstractly as a pious theory ? It is really a general name, a fine spiritual abstraction, a fictitious entity, connoting so many and varying particular consciences of all sorts and qualities. The particular conscience always rests at bottom on the particular opinion, which may be narrow, ill-informed, positively irrational, hopelessly prejudiced—the opinion of a crackbrained neurotic, a crank, a faddist, a self-sufficient lop-sided mind, the more intensely conceited the narrower it is, and in that matter, as in other matters, the prouder in its conceit of superior wisdom to despise and oppose the inferior intelligence of the community and to resist its regulations. Yet the opinion is not made sound and infallible by being invested with a sacred halo and called conscience. The

consciences of the "passive resisters" in England obliged them to resist the Education Act and count their resistance righteousness; the consciences of the suffragettes and their allies to violate the law by arson, destruction of pictures, churches and property, and by the other criminal deeds which feminine imagination conceived, and acute feminine ingenuity put into practice; and the consciences of not a few "conscientious objectors" now to refuse military service in defence of their country fighting for its existence, while comfortably claiming and obtaining the benefits of military protection by the sacrifices and sufferings of their fellow citizens' lives. The result is that everybody except the convicted criminal and the certified lunatic is entitled to his sacred conscience, of what quality soever that be, and however mean a creature he be. His formed or more often tamely received opinion he then frantically hugs, without ever giving the least thought to how he got it and what it is worth. His abstract conscience is brought into instant use to oppose the collective conscience, and consecrate his prejudiced opinion.

Obviously such opinions carried into practice by a minority of the population are not consistent with the true weal of the State and would, were they generally adopted, be its ruin. Service to the State and obedience to its laws by its citizens are the plain duty of the individuals constituting it and consenting to live in and by it, the necessary condition indeed of its strength and stability: the so-called conscientious refusal of such civil duty from whatever personal motives a proportionate weakening of its strength and hurt to its stability. The British mind, inveterately addicted to compromise, and content to deal with phrases and conventions rather than realities, shrinks from thoroughly sincere and logical thought, and when trouble comes from the breakdown of the conventional practice and decisive action is needed, thinks to surmount the danger by the appointment of a committee to consider it and report. For that reason, when real vital forces are in opposition, it is at a disadvantage in its conflict with the German mind whose systematic military organization, ingrained obedience to the State, and concentrated application of its forces under single and revered leadership, enables it to use them directly, forcibly, and effectively. By a loose organization of all sorts of committees and commissioners

and compromises promptly required action is consequently delayed and ineffectively applied; which is perhaps a practice hardly less foolish than it would be to think to win a battle by an army commanded by several loosely co-ordinated and often wrangling committees.

It is not surprising if the German military authorities—looking on the demoralised state of citizenship in England before the war, on the various resisters to law, and the licence freely granted to them to parade the streets and assault ministers, police, and others, on the interminable talk and vote-catching legislation of party politicians,<sup>(4)</sup> on the virtual emasculation of one estate of the realm by a subservient House of Commons whose members voted money to themselves for their private use out of the public revenues of which they were elected to be trustees, on the unchecked so-called peaceful but actually forcible picketing of factories by Trade Unions put above the law by law, on the lack in fact of honest leadership and effective government—thought they saw a nation sunk in selfish individuality and the sure signs of a moral decadence, and were tempted to seize the favourable opportunity of vigorous action. Obsessed with their notion of the value of their brute vital force, they overlooked the possibility of the uprising of such a latent force in England, and, disdainful of all ethical considerations in war, they underrated and despised the possible value of moral force in the procession of the human drama. Their psychology was the crude psychology of the essentially brutal Prussian nature. They had gladly embraced the doctrine of the evolution of man from the animal, and the survival of the strong in the life-struggle, but they blindly or wilfully ignored the fact that man, whatever his historical descent, is not now a mere animal, but essentially something higher, in fact a social and moral animal, who has developed and expects to continue to develop along that line of evolution otherwise than through German dominion.

That ethical aspiration has been an important and abiding factor in human development through the ages is an incontestible truth. Human ascent from its lowest stage of being to its present height witnesses positively to its operation, irregular and uncertain it may be, but on the whole undeniable and decided. However near akin to the gorilla in his historical evolution and physical structure he be, man is not a gorilla,

nor, although of the same species as the Hun, is the Hun's spirit now congenial, at any rate outside Prussia. He is not, in fact, an evolution only but an epigenesis. Even the Germans, despite their adoration and brutal use of force, feel in some degree the reality of the ethical spirit in human nature, and partially recognize it in practice. Notwithstanding their gospel of terrorism deliberately devised and systematically practised, they do not openly advocate and justify the habitual killing of the wounded and the merciless shooting of prisoners; they allow some intrusion of the ethical factor, however illogically; and they deny angrily as lies or excuse their calculated brutalities and bestial defilements of occupied houses in conquered territory, perpetrated systematically in defiance of Hague Conventions which they had agreed to observe. Brutal and brutish as they may be in practice, they resent as an insult being called beasts. The recognition that they belong to the human species and wish to be thought human is an implicit acknowledgment by them of something higher in human nature than brute animality. But so sure are they of their vital superiority and pre-eminent intellectual culture that they reconcile their inconsistency by the moral conviction that their embodiment of the highest human development is the express purpose of the Divine Will, and the justification of the supremacy which they would achieve in the world. Their Emperor loudly and exultantly proclaims the doctrine, and they in their adoration of their All Highest, and rigidly disciplined obedience to his military control as Supreme War Lord, docilely accept it and its consequences. It does not appear that a single voice from Christian pulpit or professorial chair or literary cabinet was ever raised to protest against his ruthless adjurations to his troops to imitate the Huns in the conduct of war, and the carefully framed instructions of their military manuals mercilessly to terrorize the civil population of the devastated country. On the contrary, when the war was declared and Belgium treacherously overrun with savage brutality, systematic butcheries, and unspeakable atrocities, professors, priests and pastors, theologians, and distinguished persons in literature and science hastened with one consent to assure their All Highest in a servile and laudatory address of their approval and loyalty. That any ruler of a civilized nation in the twentieth century should have seriously given the advice



and openly sanctioned the method of barbarous warfare which he exultantly proclaimed few persons beforehand would have believed possible, but perhaps not a single person could have conceived it possible that it would be enthusiastically received and endorsed by such distinguished representatives of German culture. Patriotic passion instantly swept away all quiet reflection. When a nation is hurt it feels as a whole, and responds in sympathetic and synergic unity of vital action.

The thing duly considered is not, of course, so strange as it looks on its face; it was a natural and necessary event. The three wars which Bismarck secretly devised, carefully prepared, and successfully carried through against Schleswig-Holstein, Austria, and France—in defence of German interests, as he alleged, which to him were avowedly German rights—had raised the German pride of military power and inflated the conceit of national superiority to an extravagant height, which their immensely increased and rapidly advancing material, economic, and commercial progress was not calculated to lessen; a progress so great that it was gaining, and might perhaps have continued to gain, peaceably all or more than all which they can hope to obtain by the present war. Not a single person in Germany could now perhaps be found (as the writings of their Christian pastors prove) to disapprove those wars, and their unscrupulous methods of provocation. They are approved as necessities of *international* life to which *intranational* rules of morality must be subjugated. What reason then to wonder at the patriotic outburst of exultation and adulation when their Supreme War Lord in his capacity of ruler of the State by divine right declared and entered on the greatest war in the world's history, in order to obtain and secure the domination of Germany in Europe and on earth?

What wonder again that their Emperor should have acted as he did? Think with adequate insight on his character as displayed in his speeches and conduct from the time when he succeeded to the throne, and with amazing self-sufficiency instantly took on himself the whole burden and responsibility of the government of the State as the Lord's anointed, dismissing the Great Chancellor whose genius had made it what it was. Apparently he was sincerely convinced that his grandfather, by sole virtue of being a Hohenzollern, had done the work which he had been guided and ruled to do under

Bismarck's powerful tutelage, and he, by virtue of his being a divinely instituted Hohenzollern, was perfectly competent to continue and perfect. His secret if unavowed ambition was possibly to imitate Frederick the Great, and to be as great or even a greater figure in German history by operating on a grander scale, and with the vastly augmented resources of wealth and modern military science. The greatest war in human history would be the splendid theatre of his exploit, and his glorification for ever in human admiration.

Is that perchance a misreading of his character? Let the motive have been what it may, explicit or implicit, the judgment is certainly not a misreading of his character. Think on his many eloquent and boastful orations, his sermons, his telegrams, his fierce injunctions to his recruits, his restless journeys and constant poses in the limelight, his self-confident instructions to painters, sculptors, actors, even tailors, and his indiscreet speeches which provoked the submissive Reichstag at last to a humble remonstrance and forced him to a sort of apology through his Chancellor, whom, however, he soon after dismissed. Europe looked with a mixed admiration and amusement on so picturesque a figure in its drab procession and did not take him very seriously. Yet all these exhibitions were the exponents of character which could not fail to show itself in future conduct, and just insight might have foreseen. On March 23rd, 1890, Edmond de Goncourt wrote in the *Journal des Goncourt* (vol. viii, p. 142): "Ce jeune souverain allemand, ce névrose mystique, ce passionné des dramas religioso-guerriers de Wagner, cet endosseur en rêve de la blanche armure de Parsival, avec ses nuits sans sommeil, son activité malade, la fièvre de son cerveau, m'apparaît comme un souverain bien inquiétant dans l'avenir." The history of his earlier life was the revelation of his character, and what could his later life be but its natural continuation and expression? A mystical megalomaniac was possessed with the belief that he, the All Highest in Germany by divine right, was in alliance with, and the ordained instrument of the Most High in Heaven. So he shrunk not from plunging his country into war, and his subjects, content to be autocratically governed and docilely habituated to a strict military organisation, which treated the least imagined offence to military arrogance by a civilian as a crime justifying instant killing of the culprit by

the hurt vanity of the officer, joined patriotically in the struggle.

The sequence of events was natural and inevitable. But it certainly was a painful surprise to Englishmen who supposed that the Emperor possessed some element of the quality which Englishmen imply in "a gentleman" should have sanctioned, extolled and rewarded the barbarities systematically practised. Military reasons, however, entirely obliterated such superficial feeling, if it ever existed, and furthermore justified every guile, lie, and atrocity which might serve to promote military success. An organized system of falsifications, forgeries, perversions and suppressions of truth, effected with all the thoroughness and completeness of the German national character, was deemed right for military reasons and a necessary and justifiable method of conducting military operations. The sole aim being to win in the fight, no consideration of truth or right must stand in the way of success; the matter was purely a triumph of might, and the use to be made of it in the end justified the means used to obtain it. Herein the German certainly does not conform to the English standard. Englishmen have an inveterate national prejudice in favour of fair play and strict observance of the rules of the game. It is doubtful whether there is a single well-authenticated instance of an English officer insulting or brutally treating a German prisoner, officer or private, whereas it is undeniable that there have been several such instances of assault and brutal treatment of so-called "English swine" by Prussian officers. Goethe, whose calm and lucid insight into Prussian character will hardly be contested even by Germans, said: "The Prussian is cruel by birth; civilization will make him ferocious." And that is just what has happened, even where it might have been least expected in the apparently cultivated Kaiser; a cultivation which events have shown to have been quite superficial veneer not native in character. Although his mother was English, the element of gentler breeding was instantly swept away by the uprush of native Hohenzollern brutality when the crisis came.

The truly English element must at best have been slight, for his maternal grandfather was a German, and withal a Coburg. Moreover, going further back in heredity and considering the strong stream of Hanoverian German ancestry in the English Royal family, it must have been a very thin

stream of pure English heredity which percolated downwards to affect his nature. No wonder then that it was quickly swept away by the torrent of native brutality. No wonder again that he has never shown the least sympathy with the qualities of his father's gentler character or, so far as appears, ever said a good word of him in all his manifold orations. He has gloried in praise of the coarser quality of his revered grandfather to whom he ascribed the successes which a very ordinary mind owed entirely to Bismarck's firm control and intelligent guidance. It is not in the least strange then that, brutal by Prussian birth, civilization has made the Prussian ferocious, as Goethe's prescience predicted.

So much for a cursory glance into individual psychology. But it would be unjust to Germans to suppose that they all share the brutal Prussian nature, although, having now given themselves up wholly to Prussian rule and militarism, they condone and even rejoice in the barbarities practised. That the German people as a body believe that they are fighting for the salvation of their country and are heartily imbued with patriotic feeling cannot be reasonably doubted. They believe what their rulers tell them and suffer now the consequences of docilely putting the destinies of their country into the hands of a virtual autocracy. They do not learn the real merits of the matter because they depend for what they learn on their rulers, who strictly control all the sources of information, tell them only what they wish them to believe, and scrupulously hide from them what they do not wish them to know. Democracy is nowise lovely and has its disagreeable defects and dangers, but autocracy is perhaps a greater danger to the nation and assuredly to the world.<sup>(5)</sup> In view of present events it would seem therefore to be righteously resisted in the interests of civilization and humanity, to be a fight of moral right against immoral might.

The Allies on their side, and the English in particular, might do well not to delude themselves with the notion that they are really fighting from purely righteous motives, even though their cause be the cause of true human progress. They are fighting fundamentally from motives of self-interest which will continue to operate in the future when the war is over and to produce its inevitable consequences. France is fighting with admirable bravery and unsurpassed devotion in defence of its national



existence against a ruthless attack which its past national policy and traditional glorification of Napoleon and his great victories for the glory of France have certainly done something to provoke. Russia has been moved by its Slav sympathy with Serbia, and its desire to uphold its Balkan interests, which were gravely menaced by Austrian aggression. Great Britain was instinctively urged by the necessity of preventing the destruction of Belgian independence and the subjugation of France, which would have been a great and abiding peril to her shores and to Britannia's proud rule of the waves. Each nation in fact is struggling to maintain its life and future weal against an ambitious, vigorous, and expanding nation resolved at all cost to obtain more room in the world, and the supremacy in Europe which it is sure its superiority in might and culture rightly deserves: fundamental vital forces operating from different motives the real factors at work, and the inevitable result the triumph of the strongest, since Providence is confessedly on the side of the big battalions.

The forces of the Allies are united for the time in strenuous effort and somewhat extravagantly effusive professions of sympathy and anticipations of eternal friendship which are not in the least likely to be eternal; for the attraction which now holds them together in union against a powerful enemy may quickly dissolve when their respective interests no longer coincide. Nations do not any more than individuals change their character in a miraculous manner, and knowledge of their past history is the only safe basis for prediction concerning their future. Reviewing the histories of France, Russia, and Great Britain, which are nowise stories of peaceful unaggression, and judging national character as exhibited therein, it might not be well for Europe and humanity that Germany should be so completely vanquished as to supply no effective check on their actions. The English are notably liable to waves of unthinking sentiment, and their present sentimental effusions and enthusiastic anticipations of lasting friendships with France and Russia, as expressed in newspapers and speeches which may please the populace but the judicious cannot but look on with grave doubt or amused contempt, exhibit a signally short memory and foolish forgetfulness of former and comparatively recent conflicts of interests verging nearly on war. What good reason is there to suppose that France, if it comes

triumphant and exultant out of the present war, will have the same peaceful and chastened spirit which, knowing its weakness in face of Germany's strength, it undoubtedly showed before the war? Is it expected then to repudiate its adoration of Napoleon and its glorification of his splendid victories which Germany has good cause to remember, if not avenge? Before it was vanquished and heavily penalized in the Franco-German War it did not exhibit under Napoleon III any such quiet and moderate spirit; on the contrary, it showed a quite different spirit of unrest and aggression which caused many persons to sympathize with Germany and approve her success before they learnt the story of her atrocities. The truth is that the whole history of France is a decisive refutation of the expectation of a miraculous transformation of national character. And if Russia under its present amiable sovereign may perhaps be trusted to avoid an aggressive war, though not probably its persistent habit of silent aggression—if he is not seduced or overruled by his military and interested counsellors, as in the Japanese war—a new Czar of a different disposition disposing autocratically of its forces and resources (especially if in possession of Constantinople) might endanger British interests and be thought to necessitate their defence by war. Conflict between England and Russia in the not distant future (not to speak of France) seems to cool reason a more natural and probable event than the lasting friendship which sentimental enthusiasts fatuously expect to last for ever. More fatuous withal the humanitarian optimism which expects the result of the present sanguinary war to be a complete moral regeneration of humanity, when people shall not learn war any more, when there shall be a peaceful federation of nations, when they shall institute an International Court of Justice (without troubling to devise an International Executive), when righteousness shall reign everywhere on earth. Would that stagnant state of international felicity which fancy fondly pictures—should it ever come—be a boon or a bane to the human race? The doubt need not gravely disquiet mankind: the illusion or fiction of a Paradise Regained in lieu of a Paradise Lost will be a useful incentive to endurance and effort in the pilgrimage of labour and sorrow which reason teaches that human life is, a lesson which the lust of life joying to live prevents man for ever really minding.

*Note.*

The writer of a letter in the *Spectator* of August 12th, who is serving in the war, is much saddened by the levity shown by our troops in their attacks on the enemy's trenches. "Is there not something lacking," he asks? "Is our levity altogether sound and wholesome? The spirit that jests with death, that calls through the din of the attack—'Sixpence the front row'—is it the spirit of true strength? Doesn't it lack something somewhere?" He would doubtless similarly regret the dribbling of a football in front of the attack and the reported praise of the King by the troops as "a real sport."

He and those who feel with him "have seen the hand of God in the business," and wish for the inspiration in which alone "can we find the strength of the faith that will enable us to tread in the victorious steps of those great forbears who through faith subdued kingdoms." It is a cheering thought and might no doubt be a useful inspiration, but the writer in his pious zeal neglects two considerations: he does not reflect that the Kaiser feels exactly in the same way and confidently claims the help of the "hand of God," which after rival claims can be certainly known only by the event. Secondly, the jesting spirit which he deprecates is evidence of strong and exultant vitality which will be necessary to win in the end, for the pious inspiration of faith would not avail if there were not the rude vital force for it to vivify. The reckless "jest with death," which must sooner or later come, shows a nobler spirit than the craven fear of it as "the last enemy."

(<sup>1</sup>) Le cœur a des raisons que la raison ne connaît pas.—PASCAL.—(<sup>2</sup>) Le véritable auteur d'une guerre n'est pas celui qui la déclare, mais celui qui la rend nécessaire.—MONTESQUIEU.—(<sup>3</sup>) The Vienna *Arbeiter Zeitung* calls attention to a sermon delivered at Hamburg by an evangelical pastor named Ebert. It contains passages like the following: "When it is a question of the Judgment of God, God's word knows nothing of mercy . . . God has put the sword of Justice into our hand . . . God has placed in our hands all means to defeat the enemy . . . God has given us the most brilliant leader of our days." Captain Valentiner, son of the Dean of Sonnenburgh Cathedral and the reported officer in command of the German submarine which sank the "Lusitania," has been decorated with a number of orders since the deed, including the first-class order of the Iron Cross and the Hohenzollern House Order with swords, a special distinction in the personal gift of the Emperor.—(<sup>4</sup>) Some of them belonging to what Burke describes as "the profane herd of those vulgar and mechanical politicians who, so far from being qualified to be directors of the great movement of Empire, are not fit to turn a wheel in it."—(<sup>5</sup>) The following quotation is from an article by Lord Cromer in *The Spectator* (August 19th, 1916): "Mr. Fortescue and other historians have drawn attention to the fact that the European chaos produced by the French Revolution was in some measure due to the abundance of half-witted or incapable Sovereigns who, during

the eighteenth century, governed their respective countries. The Emperor Paul of Russia was a madman. King Christian VII of Denmark was subject to intermittent attacks of dementia, as also was George III of England. Queen Marie of Portugal and Gustavus IV of Sweden were both lunatics. Charles IV of Spain and his brother, Ferdinand of Naples, were half-witted. Louis XVI of France, Victor Amadeus of Sardinia, Francis of Austria, and Frederick William of Prussia, though not of unsound mind, were all wholly unfit to occupy with advantage to their countries the exalted positions which they held."

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*The Factors of Criminal Actions.* By SIR H. BRYAN DONKIN, M.D., F.R.C.P.

AN article under the title of "The Ætiology of Crime" by Dr. Goring, in the April number of the Journal for 1918, consists to a great extent of criticisms of one by me, entitled "Notes on Mental Defect in Criminals," which appeared in the January number for 1917, and contained special comments on Dr. Goring's well-known work "The English Convict: a Statistical Study." As it then seemed to me necessary to consider Dr. Goring's views when writing on this subject, it seems equally necessary now to make some comment on his criticisms. The main reason for the following remarks is the interest and importance of the subject-matter on which he and I differ; but since some of his strictures depend greatly on misrepresentations of what I have written, or on imputations of arguments and opinions that I have not uttered, I am forced to occupy more space in this paper than I could have wished in quoting from Dr. Goring's charges and re-stating my own position.

Dr. Goring starts with the charge that I criticise "adversely an important modern idea—the idea that criminological science, that all social science, must be built on facts, and facts alone." This statement, as it stands, uninterpreted, is baseless, if not meaningless, and, at any rate, unjustifiable. If it means, as its wording unquestionably implies, that I have denied that scientific study must be based on facts only, the statement is false. If, however, Dr. Goring means that I criticise adversely his attempt to found a "criminological science" on the basis of the biometrical statistics he has worked upon, why does he not openly say what he means? It is clear throughout my paper that I do not regard the biometrical method as co-extensive with the scientific method of inquiry, and still less as the sole or chief instrument of the scientific study of things either biological or social. Whether he or I be right in our estimate of the applicability of this instrument does not matter one jot in connection with the charge Dr. Goring makes against me—a charge which, as it stands at the outset of his article, worded as it is, and totally unsupported, is acutely calculated to prejudice the



reader's mind and clear the ground for further attacks. It reminded me, indeed, while reading it, of a discharge of gas preparatory to fire.

Dr. Goring next imputes to me a "prejudice against biometry which is not shared with many other informed thinkers," thus evincing an attitude scarcely worthy of a purely unemotional and scientific disputant. He may, of course, regard me, or anyone who questions his views, as an uninformed thinker, but he does not strengthen his case by bringing this charge of prejudice, which he makes retrospective, and fails to support by evidence. He proceeds, however, to say that he has at last found, in the article with which he is dealing, some long-sought explanation of my attitude; and then makes two inaccurate and incomplete quotations from that article. By joining these quotations and thus producing them in the guise of a continuous argument he succeeds in achieving a misrepresentation of such gravity as compels me to repeat here my words as they appear in my original article, and also Dr. Goring's perversion of them.

On p. 31 of this Journal for June, 1917, I wrote as a *conclusion* drawn from *preceding* considerations: "[The totality of] the complex environment which moulds the characters of men—['physical,' 'mental,' 'moral,' 'intellectual'—and either encourages or stunts the development of their natural or inborn capacities] cannot be analysed or reduced to such items as can be established or eliminated, or reasonably dealt with, by statistical handling. [It is not possible to disentangle the various factors that contribute to the production of a criminal except in cases that may be marked by patent incapacities to acquire such characters as are possessed by the average man and are fundamentally necessary to social life. Nor is it possible to assess in any case with precision the proportionate influence of the undeniably necessary factors of 'heredity' and 'environment' in the development of a criminal man.]"

At the beginning of the paragraph next following that which I have just quoted I wrote: "[It is far from my intention to use any argument from consequences against the chief position maintained in Dr. Goring's work. Such an argument is only too common in controversy on this subject. It may, however, be fairly noted that one apparent consequence of this position seems to be largely irreconcilable with some admissions made at the end of this work.] If it be true, as Dr. Goring has proved, that law-breakers in the mass are notably less intelligent than law-abiders [and further, if it were true that their inferior intelligence is due solely to inborn incapacity], it must follow that there would be little if any reason for making efforts to reform them."

Now here, again, it signifies nothing whether Dr. Goring's or my views be right. What I desire to show is the deliberate misuse that

Dr. Goring makes of these two distinct paragraphs. On the first and following pages of his article he says: "Sir Bryan states that *the complex environment which moulds the characters of men cannot be analysed or reasonably dealt with by statistical handling*," because "if it be true, as Dr. Goring has proved" through the medium of biometry that the facts are as biometry shows them to be, "it must follow that there would be little if any reason for making efforts to reform law-breakers." Dr. Goring adds: "In other words, since biometry, by disturbing preconceived notions, may threaten the stability of our institutions, the employment of biometric methods must be deprecated."

A comparison between what I wrote and what Dr. Goring attributes to me is easily made. The words in brackets in the quotation from my article above were omitted by Dr. Goring, while all that he quoted, and imperfectly quoted, from me are printed in italics in my present quotation from him. It will thus be seen that for dialectical purposes Dr. Goring quotes from part of one paragraph, and, linking the quotation directly to part of the next by his own introduction of the word "because," gravely and falsely charges me with condemning his method because I do not like its results.

Now it is abundantly clear throughout my article that I am criticising Dr. Goring's conclusion, based on his biometrical method of inquiry, that "relatively to its origin in the constitution of the malefactor, and especially in his mentally defective constitution, crime is only to a trifling extent (if to any) the product . . . of any manifestation of what may be comprehensively termed the force of circumstances." And it is equally clear that I did not admit or even imply in the quotation I have just made from my former article that Dr. Goring had proved this conclusion. What I did imply, or rather state, was that, granting that Dr. Goring had shown that *convicted criminals* were of inferior intelligence as compared with the average man, his main conclusion seemed to be irreconcilable with some admissions made elsewhere in his own article.

A detailed reply to the argumentative matter contained in Dr. Goring's article would involve the repetition of a considerable part of my former paper, which he has either ignored or misrepresented. There are, however, some further points which call for notice.

Following on the ridiculous charge that my argument (as set forth by him) was "an appeal to the emotions in favour of an environmental origin of crime," Dr. Goring proceeds, "by parity of reasoning," to set up more "Aunt Sallies" for the pleasure of bowling them over. He quite ignores the iterated insistence in my article that crime is referable neither to "constitutional" nor "environmental" causes only, but to both combined; and he ventures to say on p. 134 of his article that I have "made a statement to the effect that it may

be laid down in advance as an *à priori* proposition, and even despite statistical evidence to the contrary, that environmental conditions must of necessity have a determining influence upon crime. He then gives his own interpretation and limitation of the meaning of "environment," drawing therefrom certain conclusions, and ends the paragraph by misquoting a passage from my article, which he characterises as an astounding outburst.

The "outburst" in question runs as follows in the original: "Even if, for the sake of argument, the [complete] validity of [the] methods employed and [of some of the subordinate] conclusions arrived at [in the "Study of the English Convict"] be assumed [including even that of the denial of any 'significant correlation' between crime and the particular environmental conditions investigated by Dr. Goring], it cannot possibly be held that any significant proportion of the innumerable influences that act upon all men from infancy to age, for good or for ill, and contribute so largely to the make-up of each of us, have been eliminated or could be eliminated by such an inquiry as we have been considering."

It is to be noted here that Dr. Goring's version of this paragraph omits all that is included within brackets, and thus becomes a perversion. Why this paragraph, with or without the words omitted by Dr. Goring, should be styled an "outburst" it is not easy to understand, unless the mere fact that in its proper and quite clear sense it contains a brief statement of my contention against Dr. Goring's chief conclusion anent the ætiology of crime is sufficient reason to mark it as another "appeal to the emotions." But this is of little moment. What does matter is Dr. Goring's further perversion, on p. 135 of his article, of what I said when writing of the "innumerable influences acting on all men, and contributing so largely to the make-up of each of us." I meant, clearly, the innumerable and various influences acting on every individual person throughout their lives; and the paragraph is part of my argument that such influences cannot be eliminated by any statistical study of men in the mass.

To touch upon another point arising from Dr. Goring's criticisms. It may be gathered from some of his remarks that misunderstanding may possibly be caused by the interpretation I have placed on the meaning of the words "constitutional" and "environmental" as used by Dr. Goring. I take it that he uses these terms, in connection with the special characters or items which he studies, as indicating two different origins which can be separated for the sake of investigation; that he denotes as "constitutional" such characters as are very commonly described by various writers as "innate," "hereditary," "transmissible," "germinal," "natural," as opposed to "acquired," "nurtural," "environmental"; and, lastly, that he means by "environ-

mental" somewhat the same as other writers mean, but with more or less definite limitations of his own.

An important question arises here, bearing closely on this discussion. If Dr. Goring boycotts the terms "innate," "hereditary," etc., and substitutes the term "constitutional," what connotation does he give to "constitutional"? By a member of the Biometrical School, "whose characteristics," he says, "are clear thinking and precision of language," it is absolutely necessary that a precise meaning should be assigned to this term, but Dr. Goring gives none whatever. I was already quite aware, and am now once more assured by Dr. Goring, that the Biometrical School repudiates the use of what it calls "figurative" terms, and employs the term "association" instead of words implying any notion of causation other than that of "uniform antecedence"; nor was I unmindful, when I wrote my article, that Dr. Goring had said that ancestral resemblance need not necessarily be due to hereditary influence. But, nevertheless, biometrical investigations undertaken into biological and social questions have, I believe, usually resulted in finding that certain degrees of ancestral resemblance are due to a "constitutional" factor; and Dr. Goring says that absence of resemblance, unless absolutely screened by environmental influences, does imply absence of "inheritance."

Biometrical teaching thus appears clearly to admit a practical dichotomy of "natural" and "nurtural" influences in the case of investigations into questions of "inheritance"; and, as Dr. Goring's researches into the origins of criminal action exemplify, this teaching includes more than the exhibition of certain statistical facts of family resemblance. It either states or implies that environmental influences can be sufficiently ascertained and studied to justify a further conclusion as to what extent these facts of family history are due to the inheritance of a *constitutional anti-social disposition apart from environmental influences*.

It is true that Dr. Goring refers to "family contagion" as a possible or alleged environmental influence which can be studied sufficiently to justify its inclusion or exclusion as a factor in crime. By this is apparently meant the personal association of the criminal with criminal members of his family, or perhaps other closely associated groups. But even such a limited inquiry into environment would be difficult in most cases, and still more difficult would be a research into the mere "school" education of persons who become criminals.

In this place it must be said, in denial of Dr. Goring's statement, that I have never implied that characters can be differentiated as either inborn *or* acquired without investigation. On the contrary, I have iterated my conviction that characters, and especially human characters, and most especially human mental characters, are both inborn and



acquired, or, if these terms are preferred, both "constitutional" and "environmental" in origin. Again, I have never said, as stated by Dr. Goring on his p. 142, that his "conclusion that crime is influenced by heredity is erroneous *because* the fact that inborn capacities are necessary for the production of human character is accepted knowledge, no longer a hypothesis in need of verification." I deny that I have ever said or even implied that crime is not *influenced* by heredity; and so far from stating that this conclusion was erroneous, I have treated it as calling for no elaborate evidence now, but as universally accepted. This charge by Dr. Goring is another example of his misuse of the word "because"—another very serious misrepresentation, seeing that it imputes to me a conclusion I did not draw, and a statement of which I have repeated the contrary.

Towards the close of his article Dr. Goring says that he cannot discover in my criticism "any sense of the fact that the aim of his inquiry was not to support speculation, but to discover what actually the relations of crime are in conditions prevailing to-day"; and he ends by stating, as his summary conclusion, that "between a variety of environmental conditions examined such as illiteracy, parental neglect, lack of employment, the stress of poverty, etc., including the states of a healthy, delicate, or morbid constitution *per se*, and even the situation induced by the approach of death—between these conditions and the committing of crime we find no evidence of any significant relationship."

In the first place, as regards the aim of Dr. Goring's inquiry, I have neither implied or thought that he wished to support speculation, or that his aim as a whole was other than he has stated it. My conception of his aim was based on his own statement on p. 18 of his original Report, when he says it is two-fold: (1) To clear from the ground the remains of the old criminology based on conjecture, prejudice, and questionable observation; (2) to found a new knowledge of the criminal upon facts scientifically acquired, and upon inferences scientifically verified, such facts and inferences yielding, by virtue of their own established accuracy, unimpeachable conclusions.

My criticisms have been directed solely to what he has written concerning his second object.

In the second place, I have from the first taken his *main* conclusion to be, not as he now states it in his criticism of my article in this Journal, but as he indicated it in p. 371 of his original work—"The English Convict." For the sake of clearness I quote once more those words of Dr. Goring's—"Our second conclusion is this: that relatively to its origin in the constitution of the malefactor, and especially in his mental defective constitution, crime is only to a trifling extent (if to any) the product of social inequality, of adverse environment, or of other

manifestations of what may be comprehensively termed the force of circumstances."

For the opinion I hold that the conclusion has not been established by Dr. Goring I have given my chief reasons in my article in this Journal for January, 1917, to which I would refer such readers as are interested in this subject. Of course, the adverse criticism that I have made of Dr. Goring's conclusions implies that I do not admit that he has founded a "new knowledge of the criminal" on the results at which he has arrived, unless his exhaustive disproof of the teaching of the "Lombrosian," or "anatomical," or "positive" school of "criminologists" may be regarded in that light.

Dr. Goring asks me, or suggests that I ought to say, what my conception of "inheritance" is, and in another place he implies by a quotation that I have given a "definition of criminology," which is, according to his gloss on it, on my own showing inherently futile. I will put my position as plainly as I can on these points. As regards the term "criminology," I have always avoided it as much as possible owing to the great confusion both in writing and thought that its use has occasioned. At the outset of my article I said that I proposed to comment on some of the recent literature of "what is known as criminology," and remarked that this term may (I should have said *might possibly*) be properly applied to investigations undertaken with a view to giving such an account of criminal conduct and criminal men as may assist in the formation of practical measures towards the prevention of the one and the appropriate treatment of the other. I have never attempted to formulate or define any special science of "criminology," nor do I deem such an attempt practicable. Dr. Goring and I both start in our study of criminals with assumptions of importance, and to some extent similar in appearance, different as the uses of them made by each of us may be. On p. 23 of my article I said, in repetition of what I had written elsewhere several years before, that "the study of criminals had long convinced me that all of us were potential law-breakers," and Dr. Goring states in the introduction to the Report on the English Convict (p. 26), that in this inquiry he is "forced to the hypothesis of the possible existence of a character in all men, which in the absence of a better term we call the criminal diathesis."

But Dr. Goring's assumption is really very different from mine; for he says—"all that we can assume, and what we must assume, is the *possibility* that constitutional as well as environmental factors play a part in the production of criminality." It is quite clear that the method of Dr. Goring's inquiry *must* make this assumption, for his object is to investigate, by a statistical method, how far crime is referable to each of these two factors respectively; but this method involves the further assumption that these two factors can be sufficiently appraised and isolated for

the attainment of the object in view. And Dr. Goring concludes, as we have seen, that environmental factors have little or nothing to do with crime-production.

My assumption, on the other hand, is a pure assumption, not made for the purpose of proving its truth, or its untruth; but though I do not attempt to prove it true by the method employed by Dr. Goring, it is clear that when I criticise Dr. Goring's conclusion I cannot justly be charged with ignoring the "constitutional factor" in crime. My assumption is necessary to my argument, and my conclusion is that Dr. Goring has not succeeded in proving that what he implies by the constitutional factor is the sole or supremely significant element in the make-up of the criminal.

Coming now to the question of my conception of the meaning of the word "inheritance," the reader will find, in my article in this Journal of January, 1917, at least a fair notion of the meaning in which I use it. All "characters" are inheritable in the sense that the capabilities of developing them, not the characters as we see them, are carried in the germ. What is commonly called an "acquired character" (this term being now used in a much wider sense than that originally attributed to it by Lamarck) is thus assuredly inheritable as any other "character." Characters are developed in response to some sort of "nurture," such as functional activity, injury, internal secretions, heat, light, moisture, nutriment, teaching, experience, etc. Thus all "characters" are products of both "nature" and "nurture," and are referable, as regards origin, both to inheritance and to acquirement—to "constitution" and to "environment." "The frequency," says Dr. Archdall Reid, "with which characters are *reproduced* (not inherited) depends on the frequency with which certain influences are encountered—certain nurture. Nurture concerns, not inheritance, but the environment. With the exception of variations in the offspring the potentiality of developing any character is inherited with certainty. Like begets like when parent and child develop under like conditions. But the *reproduction* of any character is uncertain in proportion as the environment is variable."

In Dr. Goring's inquiry the biometrical method seems to be concerned with studying frequency of reproduction—not "nature," but "nurture"—and is thus not applicable to the study of developed human characters. What the human being, over all other animals, has especially inherited is an enormous capacity for developing acquirements, and he inevitably encounters in his course innumerable opportunities for, or obstacles to, the development of these capacities. This consideration applies pre-eminently to the development of the mental characters of man which are subjects of observation, not to the necessary inheritance of his capacities for developing them.

This leads me to emphasise again an important flaw in the course of the argument which guides Dr. Goring to his chief conclusion. His reasoning necessitates the introduction, into his general conception of the criminal, of the item or factor of "wilful anti-social proclivities" in addition to the other factors of physical and mental inferiority—all of which three factors he regards as independent of each other. Now the statement that a factor in the make-up of the criminal is the possession by the offender of "wilful anti-social proclivity" is merely equivalent to saying that the man who acts anti-socially or criminally is at least in some degree of an anti-social or criminal nature, and this is tautological or meaningless as argument, unless I am mistaken in assuming that Dr. Goring classes "anti-social proclivities" in his group of "constitutional" factors. It is true that Dr. Goring, in introducing this item of wilful anti-social proclivity into his conception of the criminal diathesis, remarks that it is a bond of association with conviction for crime less close than those of physical or mental inferiority; but it is no less true that, without such introduction, the smaller, but by no means inconsiderable, number of physically and mentally superior convicts could find no place in the generalised class of men with high potentiality for crime that has been described by Dr. Goring himself. No "science of criminology" can omit from its scope the recognised number of men with good physique or high intelligence, or with both these qualities, who are convicted of crime, or the still larger number of this class of law-breakers who escape conviction altogether.

I have endeavoured in my original article, and in some additional remarks above, to show why I hold that Dr. Goring has quite failed to prove that "crime is only to a trifling extent, if to any, the product of what may be comprehensively termed the force of circumstances"; and I fail to see how Dr. Goring's conclusions have provided any new basis for the study of the genesis of crime and criminals. It is certainly true that the marks of mental or physical inferiority are much more observable in some *kinds* of criminals than in others—kinds, that is, of convicts classified by the crimes they commit. It is also true that a high degree of such inferiorities is not observable in criminals taken in the bulk, although I do not question—nor in my opinion would anyone conversant with criminals question—Dr. Goring's conclusion that *convicted* criminals are as a whole physically or mentally inferior to the non-convicted population. Further, inferior intelligence does not characterise the so-called class of "habitual criminals," who of recent years have been sentenced as such to a long term of "preventive detention," any more prominently than it characterises the other groups of criminals; nor do these habitual criminals respond less satisfactorily than others to the opportunities for rehabilitation that are provided for them



when released on licence. I make these brief statements, after reflection based on a not inconsiderable experience of many years, and corroborated during the last five to six years by a large number of interviews held with all kinds of convicts sentenced to preventive detention (with a view to deciding whether or no to recommend them for licence), and by the reported results of the cases licensed.

I am of opinion, far more strongly than when I began my observations, that even the most correct generalizations which have been or probably will be made concerning convicted criminals in the mass are not likely to be of much positive value in the study or treatment of individuals, so great are the differences of the observable characters of both criminal and non-criminal men.

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*Artes et Medicina.* By ALAN F. GRIMBLY, M.A., M.D., L.M.(Rot. Dub.).

THE question of a combined arts and medical curriculum has long been a source of dissension among the authorities of our universities, and it is my intention in these pages to lay emphasis on the enormous value of a modified arts course to students of medicine. The average student looks on the enforced study of arts askance, and regards the accompanying lectures and examinations as the deliberate attempt of a malevolent professorial hierarchy to wreck his scientific career; but in later life, when he finds himself thrust upon his own resources with education and common-sense to guide him, he unconsciously begins to reap the benefit of his B.A. degree.

Although medical students do not take the full course in arts, yet the scope of work to be done is considerable. In the University of Dublin the standard for entry to the medical school is that of the ordinary Matriculation examination, together with the term examination at the end of the first or Junior Freshman year, so that a fairly comprehensive general knowledge is required before a youth can commence his preliminary scientific studies. In the ensuing four years he attends lectures in mechanics, logic, ethics, and astronomy, devoting the Trinity term of each year to one subject, while throughout this period he is examined in English composition and instructed specially therein if found deficient. The important arts examinations are the "Littlego" at the end of the second, and the Final at the completion of the fourth year, but numerous term examinations are held at regular intervals at which a definite percentage of marks must be obtained to gain credit for the year—a highly desirable accomplishment when it is remembered that no man is allowed to have a medical degree conferred until he is qualified in arts.

There are certain subjects in the arts syllabus which are of particular

importance to the professional man. It is indispensable for marked success in the world that he should have a sound knowledge of his own tongue, a broad acquaintance with Latin and, if in less degree, with Greek, and, above all, instruction in the sciences of logic and ethics.

Medical men are renowned for their ignorance of the structure and grace of the English language. Their writings are marred by malpunctuation and the consistent use of that enormity, the "split-infinitive," and much good work is spoiled by incompetence to find expression for thought in their own tongue. The study of English essay trains men to write in a polished and cultured style, to think regularly and to reason.

Moreover, it seems absurd that many medical men should have little or no acquaintance with Latin or Greek, when one reflects that these languages form the basis of medical terminology. Every day of their lives they make constant use of terms whose present-day significance they realise, but of whose origin they are quite unaware. A sound understanding of Latin is essential for the young student to master with ease the complexity of anatomical nomenclature—a task in itself.

But I wish to lay especial stress on the importance of a thorough grounding in logic and ethics. Surely it is essential for a successful doctor to be acquainted with the "science of the form of thought"? Logic does not instruct afresh; it teaches how to think. It does not inquire into the truth or falsity of the premises but, in the conclusion, brings whatever is implied therein into the domain of consciousness. In practice correct premises depend on sound knowledge and trained powers of observation, and it is an invariable rule that an eminent physician or surgeon is a wise logician. Medical evidence in courts of law is frequently illogical, and diversities of opinion arise on this account that are in no way creditable to the profession. It is absurd if men are expected to become successful diagnosticians while they are unacquainted with the very framework of the process of reasoning, or if they are supposed to deal in wisdom with the varied problems of social life that come to their notice if ignorant of the sciences that treat of right conduct and of the workings of the human mind. Here lies the foundation of that broadness of view and clarity of thought requisite in every practitioner.

Certain objections have been raised in connection with the necessity or advisability of a concurrent arts course which may be mentioned:

(1) Additional expense entailed in the payment of fees in the arts school.

(2) Interference with work in the medical school. This is unavoidable to some extent, and it is no doubt trying to the young student to be obliged to attend lectures and pass examinations in arts when he wishes to devote all his energies to his profession; but this objection

is far outweighed by the ultimate gain later in life. Those students who, on account of such additional work, leave their University to pursue their medical studies elsewhere are generally failures, and never succeed in passing the barrier of their second or third professional examination.

(3) It is held by some people that the study of arts at all is waste of time; but such people, by heredity or acquisition, are cursed with an habitual attitude of mind that places them outside the pale of reason, and renders them immune from all argument save the *argumentum basilinum*.

The claims of concurrent education in arts to recognition as a definite phase of modern scientific teaching are manifest if we consider the advantages thereof in tabulated form :

(1) Young students are trained to form sound judgments and to think in logical sequence of ideas. Guidance in argument is afforded, and by inculcation of regular habits of thought and steady growth of the powers of reasoning the foundation structure is evolved whereby in future years difficult problems in diagnosis are grappled with in triumph.

(2) Training of memory is inseparable from cultivation of rational thought, and the power of rapid and intelligent interpretation of the objective. Only by weeding out the tares from the medley of impressions ceaselessly reaching the conscious mind, by the elimination of unessentials, can a satisfactory end be attained. Pure Reason exists only in the fantasy of early Kantian imagination; for all reason springs from a myriad association of past experiences culled from pre-existing impressions—from the memories of the bygone—and is directly influenced in the individual by the receptive and retentive faculties of the cerebral cortex. Upon accuracy of memory depend our ideas and judgments manufactured in the marvellous synthetic laboratories of the spheres of association.

(3) The origin and true significance of terms and phrases used throughout existence are understood; otherwise the language of the medical man must be but superficially intelligible to him and fundamentally incomprehensible.

(4) The sphere of education is enlarged, and the gain in general knowledge thereby is of vast importance to the practitioner in his dealings with people in all walks of life with whom he is constantly brought in contact.

(5) Knowledge of logic and ethics is essential for the preliminary study of psychology—a science much neglected in the medical curriculum. A doctor should not only be broad-minded and logical in argument, but for success should have a thorough understanding of the psychology of complex man and of possibly more complex woman.

(6) There are few occupations in which the sapient physician, who has availed himself to the best of his ability of the resources of his University, cannot take an intelligent interest. We live in a prophylactic age, and if the medical man is able to, and does, take such interest in the lives of his neighbours, particularly in the case of bodies of men found in foreign stations and ships at sea or far from civilisation, he exercises unconsciously a mental prophylaxis arising from his personality and depth of knowledge of men and events.

(7) By nature of the widened scope of University life, the student encounters every day men of his own age engaged in other lines of study, and becomes acquainted with thoughts and ideas of all sets and parties. Every medical student ought to belong to one of the established arts societies on this account. From listening to, and taking part in, debate and meeting regularly his fellows in other phases of life, his horizon is broadened, and he becomes better adapted to play his part in the eternal struggle for existence.

There are certain changes desirable in the present curriculum of our Universities, both in the arts and medical schools, which appear to me to be very greatly needed, and which ought to be put into execution with little delay. The suggestions I wish to make are the following :

(1) *The substitution of lectures in psychology for those in astronomy in the fourth year in arts.*—Scant attention has been paid to the study of psychology and insanity in the past, but some slight effort has been made in recent years to recognise their significance. The subject of mental disease has been practically left to the individual inclination, with the result that hardly 1 per cent. of students know anything about this important branch of medicine, the few that attempt to do so finding their way barred by insuperable obstacles arising from ignorance of elementary psychology. Men qualify in their profession with but the haziest notions with regard to the nature of concepts and percepts, volition, the formation of ideas, and so forth, and some are not even able to differentiate between a delusion, an hallucination, and an illusion. Men employ drugs to cause sleep without any knowledge of the theories relating to the state they attempt to induce, and a common indication of the neglect with which this science has been treated is found in the frequent use of "mind" and "brain" as synonymous terms by physicians of age and standing. The study of psychology follows in natural progression from that of ethics and logic, and it would be of enormous advantage to the profession to inaugurate lectures and examinations in this important science, and, furthermore, to lay more stress than has been the case hitherto on instruction in mental disease.

(2) *The establishment in schools of medicine of a chair of medical etiquette.*—On reflection it appears more than strange to think that this



subject should never have been regarded as a necessary part of the medical curriculum. It is unworthy of the magnificent resources of our Universities that students should be allowed to qualify with absolutely no instruction in the recognised code of professional men. Breaches thereof are sometimes committed which would have been avoided if the offender had been forewarned. It is a duty to teach every fifth year student medical etiquette for his own protection, in view of the great responsibilities that fall on his shoulders when he has his professional degree conferred.

(3) *Fixing the minimum age of entry to the medical school at eighteen years.*—I realise fully that objections are many on this point, and in particular that it is impracticable in time of war, when young doctors are urgently needed for our Navy, Army, and Air Force. But with the approach of peace in the near future it would be a wise stipulation to make. When a youth enters the school of medicine he leaves his boyhood behind, and settles down to several years' hard work if he be ambitious, and if not ambitious he fails to count in the world, where the fight for life is continuous by night and day. A boy of sixteen is too young to undertake such serious studies, and has not the physical powers of endurance, whatever be his mental capabilities; moreover, far too young is he to learn the first cruel incompatibility of life—the incompatibility of work and play.

I have endeavoured in the above pages to enumerate the benefits of a conjoint teaching in arts and medicine, but I would issue an especial warning to the unwary few who may be led astray by evil counsel into the abyss of metaphysics. There are young men who gambol through life in endless quest of the *summum bonum*—the Chief Good—wasting precious years of youth in search of eudaimonia, an eternal striving after the intangible somewhere in the nebulous zone between the exotic realms of Epicurus and the trackless wastes of the Utilitarians. Let students of medicine beware of metaphysics!

I plead for lectures in medical etiquette and regular instruction in psychology and mental disease. To quote Haeckel: "The psychologist especially acquires, by the study of mental disease and the visiting of asylum wards, a profound insight into the mental life which no speculative philosophy could give him." The foundation of a successful career is built upon education and early practice, and if a student avail himself with diligence while young of all the resources at his command, he will emerge into the world learned in his profession and wise in philosophy, endowed by his University with one of the greatest of gifts—an understanding of the Science of Life.

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*Psychoses in the Expeditionary Forces.* By O. P. NAPIER PEARNS, M.R.C.S., L.R.C.P., Temp. Capt. R.A.M.C.

At the present time, to investigate fully the psychoses of those in military service would necessitate an inquiry into the mental health of the male moiety of the entire British nation. Admitting the truism that the war has not produced any new form of mental disease, it is nevertheless interesting to bring forward and accentuate the differences and similarities found in psychiatric military and civil institutional practice.

When it is considered that a soldier on active service abroad requires observation on account of his mental condition he is sent away from his unit, usually with the diagnosis of N.Y.D.—not yet diagnosed (mental). After a varying, but, as a rule, comparatively short stay at various medical units in the country in which he is serving, he arrives at one of the specially selected hospitals in Great Britain.

At the time of writing, one of these, the Lord Derby War Hospital, has admitted over 6,000 such cases, who have all seen some form of service with an expeditionary force. Of these I have personally investigated 2,000. With such a large amount of material a medical staff varying in number with the exigencies of the service, and an amount of time varying in inverse proportion to that number, one is liable to retain only vague generalities. In order to avoid this I have thought it well to collect and tabulate some 200 cases, and use them as pegs on which to hang my facts, endeavouring at the same time to refrain from wandering in an arid desert of figures. I have selected cases which have made a sufficiently good recovery to warrant their being returned to duty, as being those concerning whom it is easiest to obtain some form of after-history either from their friends or from their regimental records, and also because the non-recoverable cases (dementia præcox, general paralysis, paranoia, etc.) resemble more closely those met with in ordinary civil practice.

Before considering these in detail it is advisable to make some remarks on the question of the war psychoses as a whole, as regards ætiology, diagnosis, and treatment.

"Stress of campaign," which is so often, and so justly, given as a primary causative factor, is by no means synonymous with stress of battle. To the popular mind, which generally figures the soldier as "driven mad" by terrifying scenes of carnage and rapine, it would come as a surprise to hear that 20 *per cent.* of the 200 cases have never been under fire, but the psychiatrist will have no difficulty in realising other pathogenic constituents inseparable from active service in a foreign land. The forcible divorce from the familiar entourage, the separation from home and family, the anxiety as to how the latter are faring, only

temporarily alleviated by correspondence, and the fear of the unknown, all serve as pabulum to the seed of mental ill-health which may already have found suitable soil in which to germinate. The effect of an entirely strange environment is emphasised by the comparative frequency of psychoses in men of alien nationality who have enlisted in colonial contingents.

Heredity only figures among the causative factors in *10 per cent.*, although special inquiries were sent to the relatives of each patient. This is obviously too low a figure, but I have long since come to the conclusion that the investigation of family histories can only be satisfactorily carried out with the co-operation of someone working outside the walls of the institution dealing with the cases concerned.

A history of excessive indulgence in alcohol was obtained in *10 per cent.* of the cases also, and it is probable that the percentage here approximates more nearly to the truth, as the physical signs of the patients and the absence of any report to the contrary in the vast majority of them supported their affirmations of temperance. A few were seasoned toppers who would have obtained means of getting drunk in the Desert of Sahara, and I have some remembrance of one who actually did. A few others had forsaken the beer of their forefathers, and followed after Bacchus in the strange and seductive guises he assumes in foreign lands.

A more frequent manner for an alcoholic psychosis to arise is in the case of the man who has been home on leave. After a period of enforced abstinence at the Front a man takes advantage of his furlough to indulge, and is found wandering about the port of embarkation on one or other side of the Channel in a confused state. This may occur even if he has taken only an amount which formerly would have had no gross effect on him, owing to his resistance having been lowered by his period of abstinence and stress. Syphilis does not figure as a causative factor in the selected cases, who are mostly too young for cerebro-spinal syphilitic affections. It may be noted in passing that general paralysis seems to have its onset hastened and its course accelerated by active service. This is in accord with the finding of Shaikewicz during the Russo-Japanese War. Syphilophobia is not infrequent, and will probably be met with more often while the education of the public in venereal disease is in the transition stage between ignorance and knowledge. Other infective diseases figure rather prominently. Of 60 cases from eastern theatres of war, *30 per cent.* gave a history of malaria and *16 per cent.* one of dysentery. It is remarkable, considering its prevalence, that in only two cases was trench fever considered connected with the onset of the psychosis, but the comparatively short duration of the acute stages of this infection is probably the explanation. As regards the front line, apart from the

obvious causes of stress, a factor frequently met with is the fear of being thought afraid.

The question of diagnosis is a very difficult one, and it is for this reason that the headings in the table are so indefinite. Incipient, aborted, and mixed psychoses all occur frequently, and borderland states are often met with. The so-called functional nervous diseases daily contribute intricate and fascinating psychological problems. It is, in my opinion, natural that the nosology should be more puzzling in military cases than in asylum practice, when the differences in the circumstances under which they are brought to observation are considered. In civil life friends and relatives co-operate with the patient in concealing eccentricities indicative of incipient mental troubles, with the result that the patient not infrequently remains without medical advice until he becomes a danger to himself or others. The doctor is finally confronted with a subject violently excited or acutely depressed, with delusions rationalised, and hallucinations of the reality of which he is firmly convinced. On the other hand, the non-commissioned officer, who in the Army stands *in loco parentis*, looks with no friendly eye on any deviation from the normal in conduct or conversation, so that the embryo psychotic finds himself receiving attention from his company or medical officer at an early stage, and the result is that he is in the hands of the specialist before many days have elapsed. The patient himself often seems to realise that a state of confusion is incompatible with the handling of lethal weapons, and reports sick at times when he would not have consulted a medical man in civil life. Difficult as it is at the best of times to pigeon-hole the infinite variations from the indefinite normal of mind, it becomes still more difficult when such variations are, as it were, half fledged.

The effect of this early attention manifests itself in results which amply compensate for any diagnostic difficulties, for these cases respond to treatment in a very gratifying way. The following summary of the cases discharged to duty does not reveal very brilliant results, but it must be remembered that these represent quite a small proportion of the total recoveries, as the majority are returned to civil life. It will be universally admitted that it would be unwise to put a recovery from a tubercle sanatorium to work in any place where he stands a chance of reinfection, and it is equally unjustifiable to subject the ex-psychotic a second time to the stresses and strains under which he broke down. The 200 exceptions instanced herewith are mostly men who have manifested a strong desire to put on khaki again, and signified their intention of re-enlisting if discharged to civil life. It will be noticed that about 26 *per cent.* are regular or re-enlisted soldiers. These return to a familiar environment, and are often men more at home in the Army than anywhere else who are less likely to be subject to the very real



mental pain of nostalgia. Home service for twelve months is the rule for these cases, but it is difficult to keep a man back when his friends are going to the front, and this doubtless accounts for the large proportion noted as having found their way overseas again. In spite of the discrimination employed the percentage of definite recurrence is 15, a number of others (12 *per cent.*) have been subsequently discharged from the Army, and the quota known to be doing well at the time of inquiry is but 47 *per cent.* In view of these facts, it is doubtful whether, from the national point of view, the occurrence of a psychosis should not be an absolute bar to any form of military service. It seems questionable whether the good work done by those who remain stable is enough to compensate for the trouble and expense involved in dealing with those who have a second attack, while if returned to civil life the latter would probably be useful assets to the State.

With reference to treatment, it will be found that the soldier is, broadly speaking, a good subject for institutional care. Subject as he is to a disciplined life, he does not find routine irksome, and is appreciative of privileges. A system of parole for convalescent patients does much to re-establish self-confidence. Comparatively few sedatives are found necessary, many of the patients being at a stage when a drachm of psychotherapy is worth an ounce of paraldehyde. I have found a popular exposition of Claparède's theory of sleep useful in some cases of insomnia. The visits of a kindly and tactful committee of ladies are much valued, and contribute, I think, towards doing away with any feeling of being sequestered from the outside world. Such adjuncts as massage, electrotherapy and hydrotherapy are found useful from time to time.

In exhaustion cases mental and bodily treatment should go hand in hand; as the patient's weight increases his mental readaptation should be aided by psychotherapeutic conversations. Without this cases of "institution cure" will result. The patient appears so rational and well-behaved that it is not thought necessary to detain him any longer, but he has never obtained any real insight into his condition, and breaks down again on the slightest provocation after his return to the outside world. In the psychoneuroses I incline to explanatory methods rather than to suggestion *per se*. The latter yields excellent results as regards isolated symptoms but does not touch the root of the matter. Intensive suggestion is very valuable in patients too opinionated or feeble-minded to appreciate explanations.

Occupation is essential to recovery; but it must not be of such a kind as cannot be done automatically, and is congenial to the patient. Patients are told to aim at the ideal of being always interested and never tired. Such things as fancy needlework, artistic work, mat- and basket-making are very valuable as being easily graduated employments

at which the patient can recover self-confidence as he sees his output increasing. As soon as his fatiguability has sufficiently decreased he may be put to some outdoor occupation.

*Summary of the 200 Cases.*

Care has been taken to exclude cases whose history was incomplete, and those in whom the difficulties of diagnosis were so accentuated as to make it doubtful as to where they should be placed in the very elementary classification adopted.

Excluding professional soldiers, the composite picture obtained by taking averages of these is that of a man, æt. 27, who has had eighteen months' total service in the Army, ten of which have been spent on active service abroad. He has then had an attack of mental trouble which has lasted about four months. In connection with the duration of the psychosis, it is interesting to note that of 149 cases discharged from the London County Asylums in 1913, in only 63 did recovery take place in less than six months. I refer, of course, to cases of parallel age to those forming the subject of this article. In all but 12 *per cent* I have been able to obtain some data as to their career after leaving hospital, and have embodied some of the findings. The time of inquiry varied between eight months and two years after their leaving the institution.

*States of excitement.*—Under this heading have been placed all cases presenting the physical signs and mental symptoms of mania, but it is quite likely that some have been included who really belong to an exuberant phase of an exhaustion or other psychosis.

*States of depression.*—Striking similarities occur between the figures relating to these cases and those referring to cases placed in the foregoing category. It will be noticed that the average age is slightly higher. Men previously in the Army form a considerably higher proportion here, and I suggest that the subconscious comparison between service in the present times of crises and in peace time may have an influence in the direction of depression. It is possible that in some cases included here the depression is but secondary to a delusional state, which in those noted as not doing well after discharge has reasserted itself. The fact that in only one out of six cases with an alcoholic history was the subsequent progress satisfactory rather supports this view.

*States of confusion.*—The majority of the exhaustion psychoses are placed here, together with a few cases of acute delirium. A source of endogenous or exogenous toxæmia is traceable in most of them. It has been stated that neurasthenics never become insane, but when it is considered how much real fatigue is associated with a state of neurasthenia, and the amount of mental energy expended on processes

that are normally automatic, it seems only reasonable that they should be more, rather than less, liable to the ill-effects of fatigue products. It is certain that many definitely psychotic cases are met with who have been what is now generally described as neurasthenic prior to the onset of their psychosis, and remain so after their return to their apparent normal.

It is amongst confusional states of exogenous toxic origin that the cases most fitted for further service are found, as would be expected from consideration of the incidental nature of their most important ætiological factor.

*Psychoneuroses.*—Every variety of mental affection, from general paralysis of the insane downwards, has at some time or another been admitted with the label "shell-shock." The cases classified here under that heading are those who have exhibited acute functional symptoms such as paraplegia or aphonia immediately following on some source of extreme emotional excitement, such as being buried, or knocked down by the windage of an explosion. In many cases a source of worry antedating this for a variable period of time is discoverable, and the shock has only acted as the culminating factor—the final crystal to the supersaturated solution, to use a hackneyed simile. The great preponderance of cases from the Western Front shows what a definite relation the frequency and intensity of shelling bears to the incidence of these troubles. Some of those classified here under neurasthenia commenced their psychopathic career with similar symptoms, but these had passed off at the time of their admission, leaving them in a condition the most salient features of which were tremulousness on the physical side, and lack of concentration on the mental. In other cases the onset took the form of a period of amnesia. It will be seen that these cases have not done very well after discharge, but it must be remembered that only those bad enough to be considered "mental" have been admitted, and that limitations of time have prevented that "following-up" treatment which is so desirable.

*Delusional states.*—Exclusive of a few alcoholic cases these have been mostly of a paranoidal nature, and such as one would have ordinarily regarded as unlikely to improve. With explanatory treatment many of these clear up even when they have had definite ideas of reference with some attempts at systematisation. Cases of paranoia proper have been comparatively rare. The average age, total service, and foreign service are all higher in this class than in any other.

*Mental defectives.*—Those considered here are naturally of high grade, men of poor general mental development who have been considered capable of coping with manual labour on home service. Two cases of "mental instability" have been included—subjects who developed attacks of irritability and intolerance of discipline due to

	States of excitement.	States of depression.	States of confusion.	Psycho-neuroses.	Delusional states.	Other psychoses.	Mentally defective.
Number of cases { western theatre of war . . . . .	32	28	35	20	12	8	8
Average age . . . . .	11	13	21	2	4	—	6
" total military service (in months) <sup>1</sup> . . . . .	28	30	27.5	25	32	25	24
" service overseas (in months) . . . . .	21	19	20	19	22	18	16
Number of regular or re-enlisted soldiers . . . . .	9	10	12	10	14	8	9
Average duration of psychosis (in days) . . . . .	8	14	16	7	4	3	2
Cases with history of previous attack . . . . .	128	126	121	123	121	151	107
" who had either { old wounds . . . . .	5	7	4	2	1	1	—
" { recent wounds . . . . .	3	7	7	3	1	1	1
" with history of excess in alcohol . . . . .	1	1	3	1	—	—	—
" with psychopathic family history . . . . .	6	7	3	2	4	—	—
" who had not been under fire . . . . .	6	5	2	2	2	—	2
" still presenting symptoms at time of inquiry . . . . .	11	10	9	1	6	—	2
" who had a relapse or second attack . . . . .	5	8	3	4	1	1	1
" doing well at time of inquiry . . . . .	5	5	8	4	3	4	1
" discharged from the army subsequently <sup>2</sup> . . . . .	22	16	38	3	7	2	6
" sent on foreign service again . . . . .	3 <sup>3</sup>	8	3	5	2	—	4
" not traced since discharge from hospital . . . . .	15	9	14	1	2	1	3
" . . . . .	5	4	4	5	3	1	2

<sup>1</sup> Excluding regular and re-enlisted soldiers.<sup>2</sup> In the majority of cases invalided with some such disability as "neurasthenia."<sup>3</sup> Two others in hospital at time of inquiry. Nature of complaint not known.



failure of adaptability. Both of these have had fairly long service, as also had one man whose defect was chiefly on the moral side. Excluding these, it is remarkable how little active service causes a mental defect to become obtrusive even in those who have done fairly well in the Army at home.

*Other psychoses.*—Five cases of dementia præcox are included under this heading. Although the average time under treatment has been a month longer than that of any other class, none of these have done really well. In spite of an apparently complete recovery, their subsequent history shows that what was obtained was only a remission. There have been many cases which at first seemed to be dementia præcox, the catatonic, hebephrenic, and paranoid forms being simulated, but which have cleared up very quickly without leaving any mannerisms or psychopathic aftermath. These I regard as cases of “regression”—an attempt at adaptation on lower psychic levels when the superior functions are in abeyance. Capt. Maurice Nicoll, in the *Lancet* of June 8th, 1918, summarises them well in the following words: “Persons who showed a greater or less degree of infantility, with abnormally reinforced fantasy or dream life.” In the present paper they have been placed with the confusional states. Two cases classed as impulsive insanity were unstable subjects who had committed impulsive actions through increased irritability under strain rather than under the influence of true obsessions or imperative ideas. In the one case of stupor the condition was preceded by a short period of excitement.

#### *Conclusions.*

While laying claim to no new discovery, I think that the facts presented in this article furnish additional arguments in favour of three propositions which have already received some support.

(1) That the early treatment (compulsory or voluntary) of psychotics is very important.

(2) That the presence of a psychiatrist on medical recruiting boards is very desirable.

(3) That careful consideration before returning a man who has suffered from an established psychosis to military service is very necessary.

### Clinical Notes and Cases.

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*A Short Note on the Use of Calcium in Excited States.* By T. C. GRAVES, B.Sc., M.B., B.S.Lond., F.R.C.S.Eng., L.R.C.P.Lond., Temp. Capt. R.A.M.C.

ACCORDING to Prof. William Bayliss, calcium is necessary for the normal effect of adrenalin on sympathetic nerve-endings. Acting on the assumption that in acute excited states there can be no lack of adrenalin in the body but an absence of its "fixation ion," I have exhibited calcium lactate in ten-grain doses to many cases of more or less acute excitement with satisfactory results. The cases include, of the manias: epileptic, simple, delirious, and recurrent; agitated melancholia and recent acute hallucinations. The effect of the drug is to calm the mental state and improve the physical condition. A rapid, weak pulse becomes slower and stronger, any diarrhoea present ceases or is improved, a dry, harsh skin becomes moist and supple, the appetite also is improved. The younger the case the better the result, similarly the more recent the case, especially if of influenzal origin. Some of the cases, however, have responded although over forty years of age, and several old-standing cases have shown a temporary improvement.

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### Part II.—Reviews.

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*Diseases of the Nervous System: A Text-Book of Neurology and Psychiatry.* By Drs. SMITH E. JELLIFFE and W. A. WHITE. Second edition. Philadelphia and New York: Lea & Fibiger. 1917.

The form of this book is best described in the authors' own words—"a work on the diseases of the nervous system rather than two books, one on neurology and one on psychiatry, which would perpetuate a distinction which the authors believe to be artificial." A work written from this standpoint should be welcome after the numerous clinical volumes compiled on the supposition that the lower realms of nervous action have little more than a bowing acquaintanceship with the cerebral cortex.

The volume has been divided on physiological lines into three parts which treat respectively with the vegetative (endocrino-sympathetic), the sensori-motor, and the psychic systems, between which there is uninterrupted reaction; and all the clinical entities under these headings are dealt with in a remarkably clear fashion. The book opens with a useful and concise chapter on methods of examination, in which

important points are illustrated by photographs of the clinical features and diagrams of the spinal or cerebral area involved. We note that some of Dejerine's figures have been made use of to the advantage of the reader.

Part I, "The Physio-Chemical Systems," which deals with vegetative or visceral neurology, contains much information of value to the clinician, and emphasises the relationship now known to exist between this system and psychic function. The writers are impressed with the important correlations which exist between the lower or vegetative mechanism and cerebral disturbance, especially in the emotional field. "The rôle of this system (vegetative) in its reaction to mental stimuli . . . has helped to give an interpretative status for empirically held beliefs": and the anatomical foundation for this statement is that "the ganglionic system which in man serves the vegetative functions of the body is represented in the primary metameræ, the spinal cord, again in the brain-stem, central grey matter and mid-brain, lenticular nucleus and optic thalamus (hypothalamus), and finally in the cortex, where the different organs under vegetative control have localisation as surely as those of the body musculature." Throughout this chapter there is ample clinical evidence in support of the view that faulty stimuli at psychological levels can and do produce equally faulty reactions in the vegetative sphere, and *vice versa*.

Part II is concerned with sensori-motor neurology, and although this section is rather compressed, the authors have succeeded in giving a clear account of the symptomatology. The subject matter is well illustrated by photographs and anatomical diagrams, some of which are, as noted under Part I, taken from Dejerine's work.

In Part III, "The Psychical or Symbolic Systems," we note that psycho-analysis occupies a prominent position, especially in its application to the ætiology of mental disease. Emphasis is laid upon failure of mental adjustment to the difficulties in life with its consequent egocentricity, introspection, defective reaction, phantasy formations, conflicts, repressions, and dissociations. In this mechanism infantile pleasure-seeking plays an important part, and on this point there are some interesting illustrations under the "compulsion neurosis."

Manic-depressive insanity is, according to the authors, "an effort at compromise and defense resulting from an endopsychic conflict." "In the depressive stage the affect has broken through and invaded consciousness, while in the manic phase the patient, by feverish and restless activity, by constant alertness, fights off every approach that might touch him on a painful point, that might reach a vulnerable spot." The patient flies into reality to avoid the conflict, hence he is "extroverted."

In direct contrast to this a patient suffering from so-called dementia præcox is "introverted." Here there is a splitting of the personality which results in regression to the infantile and archaic in the individual, thus permitting older phylogenetic thought symbols to appear in conduct. Somatic disturbances in the realm of the vegetative nervous system assist in this process, although the authors admit that prominence must be given to the psychic factor. Still, though the mental symptoms may be psychogenetic their reaction on the sympathetic system cannot

be ignored. In this connection attention is directed towards considering the patient as a unit in whom no distinction can be drawn between mind and body.

The whole work contains many suggestive thoughts. To many these may appear to have an insufficient basis; to others they will be welcome on account of their very suggestiveness. The book, however, apart from controversial matters, has the special merit that it links up neurology with psychiatry, both of which have been separated too long to their mutual detriment. The whole nervous system must be treated as one single entity, and the writers have, and with considerable success too, given the reader an insight into many of the problems dealing with the interaction of its several parts.

DAVID ORR.

*Mysticism and Logic.* By BERTRAND RUSSELL, M.A., F.R.S. Longmans, Green & Co., 1918. Pp. 234, 8vo.

This volume consists of a series of essays by Mr. Russell which have previously been published in other collections and various journals. In so far as some of these essays are out of print and others may be inaccessible to the general reader, the present collection will be welcome to those who are acquainted with the philosophic works of the author, as well as to those to whom this volume may open up new ground. Perhaps one of the chief charms of this collection, from the point of view of the ordinary reader, is the fact that several of the essays are not highly technical in presentation, and thus it becomes possible, without any special knowledge of philosophical methods of expression, to obtain a useful insight into the view-point of the leading exponent of the New Realism—a system of philosophic thought with which the name of Mr. Russell is particularly associated.

In the first essay, which furnishes the title to the book, the writer outlines what he conceives to be the necessary attitude for the erection of a truly scientific philosophy. He shows how most philosophic systems have been really no more than the rationalisation of preformed intuitive beliefs, and that the conceptions of the universe which are presented by such systems are subjectively determined—a reflection of our inner emotions and wishes which view the world as we should like it to be, rather than as it actually is when viewed with scientific detachment. Philosophy should above all be ethically neutral, and freed from such terms as “good,” “evil,” “progress” and the like in seeking to explain the phenomena with which it deals, if it is to attain scientific success. To quote the author: “The physicist or chemist is not now required to prove the ethical importance of his ions or atoms; the biologist is not expected to prove the utility of the plants or animals which he dissects. In pre-scientific ages this was not the case. Astronomy, for example, was studied because men believed in astrology; it was thought that the movements of the planets had the most direct and important bearing upon the lives of human beings. Presumably, when this belief decayed and disinterested study of astronomy began, many who found astrology absorbingly interesting decided that astronomy had too little human interest to be worthy of study. Physics, as it appears in Plato’s



*Timaeus*, for example, is full of ethical notions : it is an essential part of its purpose to show that the earth is worthy of admiration. The modern physicist, on the contrary, though he has no wish to deny that the earth is admirable, is not concerned, as physicist, with its ethical attributes ; he is merely concerned to find out facts, not to consider whether they are good or bad. . . . In philosophy, hitherto, ethical neutrality has been seldom sought and hardly ever achieved. Men have remembered their wishes and have judged their philosophies in relation to their wishes. Driven from their particular sciences, the belief that the notions of good and evil must afford a key to the understanding of the world has sought a refuge in philosophy. But even from this last refuge, if philosophy is not to remain a set of pleasing dreams, this belief must be driven forth. It is a commonplace that happiness is not best achieved by those who seek it directly, and it would seem that the same is true of good. In thought, at any rate, those who forget good and evil and seek only to know the facts are more likely to achieve good than those who view the world through the distorting medium of their own desires."

It is not the affair of the psychiatrist, as such, to follow in all their refinements the opposing claims of realism and idealism as schools of philosophy ; and it is certainly not the province of the reviewer to discuss these vexed questions, but it does seem that such views as the above establish a direct point of contact with those whose more particular interests are the problems of normal and abnormal psychology. Is it not the aim of the psychiatrist to lead back his patients to reality, to break down the defensive erections which serve to protect them from a strenuous adjustment to life, and thus to carry into practice, as far as it is possible or advisable, the theoretical aim of the philosopher? Modern researches tend to demonstrate increasingly to what an extent the world is viewed in accordance with hidden desires, how strenuously individuals will defend irrational beliefs founded upon unconscious cravings, and how even dependence on some external power behind the immediate painful experience of reality can be traced to inner tendencies of which the individual is unaware.

That human beliefs depend on instinctive and emotional factors always will be the case as applied to every-day thinking, but, as Mr. Russell says, scientific philosophy, in its particular aims and sphere, should come nearer objectivity than any other human pursuit. It will not pretend to satisfy the inner cravings and needs of humanity, or offer "the glitter of outward mirage to flatter fallacious hopes," but it will lead to the acceptance of "the world without the tyrannous imposition of our human and temporary demands," and thus furnish its own intellectual reward. In such a conception of philosophy there is, of course, no attempt to ignore the practical importance of ethical teaching ; on the contrary, underlying these essays it is possible to detect the expression of the perhaps truly religious attitude towards life and experience, but in this volume the true sphere of philosophy is narrowed down and defined—"it aims only at understanding the world, and not directly at any other improvement of human life."

The best religious thought of the present day is by no means static or reactionary : it is freeing itself from traditional influences, it tends to be increasingly ethical in teaching, and finds practical expression in a

variety of necessary and beneficial social activities. Perhaps in so far as its assumptions are recognised as intuitive in basis, so will its influence be more cogent, but unfortunately there is a tendency at the present time for a considerable section of the community to associate themselves with pernicious modes of thought, disguised under a cloak of pretentious philosophic or pseudo-scientific phraseology, which can only be characterised as harmful regressive tendencies—to use the terminology of modern psychology. The reference is obviously to spiritualism, which, though disguised by an apparent attitude of detached scientific impartiality, is yet so clearly determined by the mechanism of “wish-fulfilment,” and also Christian Science, an instance of that tendency to evasion of reality which ignores and denies the existence of what is painful—crudely expressed, the traditional policy of the ostrich in danger.

To mention these modern tendencies, which are no doubt to some extent an inevitable reaction after years of stress and loss, would not seem here to be out of place, since it is such a vigorous facing of reality, such clearness of vision, and such an attitude towards experience as find expression in this volume, combined with a humble recognition of the limits of knowledge, which may tend to counteract the frank and aggressive assumptions, the product of distorted desires and mistiness of thought which are contained in the various pseudo-sciences and philosophies now springing into such prominence.

Some chapter headings will indicate the scope of the subjects considered. In “The Place of Science in a Liberal Education” the author defines education as “the formation by means of instruction of certain mental habits, and a certain outlook on life and the world.” In “A Free Man’s Worship” is suggested the attitude towards life of those who have no dogmatic religious belief; perhaps a rather depressing though lofty outlook is here presented, perhaps, also, inevitably so; and essays on “The Study of Mathematics” and “On Scientific Method in Philosophy” contain much to stimulate and interest.

Throughout these essays Mr. Russell insists on the importance of seeking for truth in itself rather than for any material rewards research in any direction may bring; so that though scientific philosophy may have no directly ethical aims, yet the principles underlying it have definitely ethical value for those who carry them into practice. All those who are interested in any branch of science will find much in this volume to inspire, and they will certainly gain a clearer vision of what the scientific attitude towards experience should be. This is expressed in the following quotation, in which Mr. Russell is discussing the lack of the scientific spirit in philosophy: “Philosophers and the public imagine that the scientific spirit must pervade pages that bristle with allusions to ions, germ-plasms, and the eyes of shell-fish. But as the devil can quote Scripture, so the philosopher can quote science. The scientific spirit is not an affair of quotation, of externally acquired information, any more than manners are an affair of the etiquette-book. The scientific attitude of mind involves a sweeping away of all other desires in the interest of the desire to know—it involves suppression of hopes and fears, loves and hates, and the whole subjective emotional life, until we become subdued with the material, able to see it frankly without preconceptions, without bias, without any wish except to see it

as it is, and without any belief that what it is must be determined by some relation, positive or negative, to what we should like it to be, or to what we can easily imagine it to be."

Emphasis has been laid on those elements in this volume which suggest what should be the general attitude towards scientific investigation in whatever particular sphere. Much scientific work is by no means free from bias and preformed opinions, and it is perhaps inevitable that it should be so, mental life being what the psychologist knows it to be. Nevertheless, the mental attitude towards phenomena indicated in the above quotation may well be the ideal at which the scientist aims, however difficult it may be in practice.

To do this volume full justice, however, it should be mentioned that several essays are more technical in character, and will thus be of special value and interest to the student of philosophy. The following titles will serve to indicate sufficiently the full scope of this collection, *viz.*, "The Ultimate Constituents of Matter," "The Relation of Sense-data to Physics," "The Notion of Cause," and "Knowledge by Acquaintance and Knowledge by Description."

H. DEVINE.

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*Essays in Scientific Synthesis.* By EUGENIO RIGNANO. Translated by J. W. GREENSTREET, M.A. London: Allen & Unwin, 1918. Pp. 254. Price 7s. 6d. net.

Sig. Rignano, of Milan, is the able and energetic editor of the international review, *Scientia*, published in Italy, and he has shown himself indefatigable during the war in bringing together distinguished scientific and philosophical contributors to his review. He is also, however, a remarkable thinker and writer whose penetrating and suggestive essays seldom fail to throw light on old questions or to advance new questions. He excels in showing how one branch of scientific activity may fertilise or illuminate another branch. This attitude of mind is revealed, as indeed the title indicates, in the present volume, which consists of a series of separate studies on the rôle of the theorist in biology and sociology, the synthetic value of the evolution theory, biological memory, the mnemonic nature of affective tendencies, the nature of consciousness, the religious phenomenon, historic materialism and socialism. Diverse as the subjects may seem, the spirit and object, as the author points out in the preface to the English edition, are the same: "That of demonstrating the utility in the biological, psychological, and sociological fields of the theorist, who, without having specialised in any particular subdivision of science, may nevertheless bring into those spheres that synthetic and unifying vision which is brought by the theorist-mathematician with so much success into the physico-chemical field of science." In the introductory essay the author sets forth clearly the beneficial part which the theorist, able to embrace impartially the opposing views due to the inevitable limitation of the specialist, may play in the advance of science. He refers, for instance, to the problem aroused by vitalism, to the contests between physiologists and psychologists, both in part right, concerning affective phenomena, to the attempts of psychologists and sociologists to appropriate exclusively the phenomena of religion which rightly

belong to both, and he adopts the mnemic theory—now gaining increased support in its reconciliation of the advocates and opponents of the transmission of acquired characters—which he uses fruitfully in some of the subsequent chapters.

The mnemic theory, with its insistence on the organic impress of habit, is visible, indeed, in the following essay on the synthetic value of the evolution theory. Summarising the contest between the preformist and the epigenetist, each of whom can bring forward a long series of facts which tell dead against the other, Rignano finds support for his own centro-epigenetic theory (set forth in an earlier volume), according to which the development of each part would depend not on that of all the other parts of the soma, but rather on the continuous action which the germinal substance of the central zone exercises on the rest of the organism during development. The wonderful phenomena of the recapitulation of phylogenesis by ontogenesis, he insists, is simply an aspect of an essentially mnemic phenomenon, a sign that the living substance remembers all the stages through which the species has passed in consequence of the continuous acquisition of new characters successively added to the old. Here, in "this affirmation of profound and unsuspected analogies between the vital phenomenon in general and the mnemic phenomenon, enabling us to conceive of the latter as the fundamental substratum and inner essence of the former," we have "an imposing synthesis of biology and psychology." "All vital phenomena are also mnemic."

In the essay which follows, the author summarises clearly his centro-epigenetic theory, confronting it with many established facts, and argues that the law of the recapitulation of phylogenesis by ontogenesis is the immediate consequence of the transmissibility of acquired characters in the mnemic sense, as understood by Hering, Semon, Butler, and Francis Darwin, the mnemic faculty being the corner-stone of the centro epigenetic hypothesis.

An instructive and searching study follows of the mnemic origin and nature of the affective tendencies. In a certain sense Rignano would accept a somatic or visceral basis for the fundamental affective tendencies, constituted by "an infinite number of elementary specific accumulations, differing from point to point of the body, and whose combined potential energy would form, as it were, a force of gravitation." Hence special affectivities originating by way of "habit." Everywhere we find verification of Lehmann's law of "the indispensability of the habitual," which he established for every stimulus to which one grows accustomed, and in the absence of which we become conscious of a "need." Maternal affection, as resting upon lactation, is here instanced. We must attribute a similar mnemic origin, the author believes, to all the affective tendencies, since the innate and the acquired do not differ in their nature. "Habit is second nature," and that adage must be completed by the inverse axiom—"Nature is nothing but first habit." In this connection Rignano (like Stout) insists on the important distinction between affective tendencies and emotion, and criticises the confusion into which Sherrington has fallen at this point. Every emotion presupposes an affective tendency, but an affective tendency by no means necessarily involves an emotion. If we see a vehicle



approaching in the distance an affective tendency leads us to step calmly out of the way; if it suddenly comes on us round a corner we experience an emotion and dart out of the way. It is not the *emotion* which impels us, it is the *affective tendency*; the emotion is but the reaction of a too rapid or intense realisation of the affective tendency. The will, Rignano declares (in harmony with Maudsley), is nothing but a true and characteristic affective tendency. "The mnemonic property, the property of 'specific accumulation,' is everywhere present in organic nature, and makes the world of life a world apart, of which the most essential characteristics cannot consequently be explained by the laws of physics and chemistry alone."

What is consciousness? This is the subject of another study, and the author concludes that a psychic state is not in itself either conscious or unconscious, but becomes one or the other in relation to some other psychic state. Consciousness is thus not an intrinsic and absolute property, but extrinsic and relative.

In dealing with religious phenomena, Rignano attaches primary importance to the propitiatory attitude as unknown in animals (though surely one may see it clearly in the domesticated dog), but appearing early in the struggle between man and man. "The first man who threw himself prostrate, but no longer before another man, was the first believer and the first founder of all religions." Other elements, it is admitted, become associated, but propitiation assumed struggle, and also assumed that something was to be gained by the weaker from the stronger party, who might be turned into an ally or protector. In keeping this weaker party in parasitic subjection the stronger party could make use of religion to fortify his power, for religion tends, as Reinach remarks, to become an aggregate of taboos. All law thus has a religious origin, and the social order at first rests entirely on religion. In developing his exposition the author insists much on the primitive importance of war: "No social activity set the religious organ in motion more notably than war," which we must consider as "the greatest, the most universal, and the most fundamental of all social activities." Let it be added at once that the author believes that "war is condemned to disappear," like cannibalism; as also religion (except in so far as it is the sweet and intimate consolation of the individual soul) is condemned to disappear, since both war and religion gain their power from primitive social conditions which are now passing away. It may, however, be pointed out that the view here accepted as to the immense significance of war in primitive society is contested. It is not accepted by many distinguished sociologists. There are many good reasons for believing that war only developed very slowly; even to-day among savages in the most various parts of the world war is not a serious matter, and Sig. Rignano would be well advised to study the powerful arguments and array of facts brought together by the Finnish sociologist Rudolf Holsti four years ago in his book (published in English) on *The Relation of War to the Origin of the State*.

While, however, it is sometimes possible to differ from the author, there can be no difference of opinion as to the suggestive and stimulating value of his vigorous and thoughtful book, which is nearly always well abreast of current research and speculation.

HAVELOCK ELLIS.

### Part III.—Epitome of Current Literature.

#### 1. Psychology.

*Why is the "Unconscious" unconscious? (The British Journal of Psychology, October, 1918.) Nicoll, Maurice, Rivers, W. H. R., and Jones, Ernest.*

Three papers which were contributions to a symposium at a joint session of the British Psychological Society, the Aristotelian Society and the *Mind* Association. Dr. Nicoll presents the teaching of Jung upon the nature of the "unconscious." To Jung the primitive life force, or *libido*, is not sexuality, but an energy one of whose manifestations is sexuality. He supposes the "unconscious" to have two constituents, the one, the *personal unconscious*, derived from repressed and forgotten material that has an intimate and personal significance, and the other, the *collective unconscious*, impersonal and made up of *primordial thought-feelings*, which form the primitive pattern of all thought, and which is worked up, according to the mental powers, into more or less elaborate thought-systems. It would seem that potentially in the "unconscious" of all people are equal possibilities of achievement in any sphere of thought, the conscious expression being a matter of individual capacity for elaboration and detail. Thus material included in the "unconscious" may find expression in a vague inarticulate feeling which eludes definite formulation, it may find expression in the phantasies of dementia præcox, or it may be adapted to reality and reach definite systematic formulation in the production of genius.

The "unconscious" is thus unconscious because it is nascent thought—thought which is not yet adapted to reality. The view is an evolutionary one. The progressive transmutations of psychic energy are carried out at levels beneath consciousness, just as the progressive transmutations of the embryo are carried out in the womb of the mother, and it is only the comparatively adapted form that is born into waking life.

In the second paper Dr. Rivers points out that Dr. Nicoll more or less ignores the *personal unconscious*, and deals with the unconscious with which man is endowed at birth, the latter being identical with that which the psychologist knows as instinct. Dr. Rivers devotes his attention to what are generally known as dissociations of consciousness, *i.e.*, elements of mental life which become unconscious, and only enter conscious mental life in sleep or hypnosis, or in waking life under special conditions. He seeks an answer to the following questions: (1) Why should an experience become unconscious? (2) why, having become unconscious, should it persist in a dissociated state, ready to appear in consciousness after years of dormancy, if special conditions arise? In considering the first question he shows that in some forms of animal life, *e.g.*, the frog, instinctive phases of experience must pass into a state of unconsciousness in the widely

differing phases of life-history since the instinctive needs and conditions of life are so different. Similar, if not such striking, differences occur in the life-history of man, and infantile instinctive reactions which are incompatible with the reactions of adult life must become unconscious. Proceeding on these lines the writer suggests that dissociation is a state especially prone to occur whenever it is required to put instinctive modes of reaction into abeyance, to suppress instinctive modes of behaviour which would interfere with the harmony of an existence based on less immediate and more modifiable reactions.

Though instinctive reactions are especially susceptible to dissociation, complete suppression does not occur in human beings as in the case of insects and amphibians in varying stages of development. In man in whom instinct has become subject to reason the process has been employed in a selective manner, certain elements of the instinctive complex having been suppressed while others have been combined with later modifiable modes of reaction. This affords a clue to the second problem as to why the unconscious should persist. What is incompatible with the intelligence in instinct is subject to suppression or dissociated, but part of the instinctive process is still utilised to form products blended with reason. The experience which is dissociated persists, partly because of the inherent vitality of instinct, partly because the suppressed experience usually forms an integral part of a complex, other constituents of which have been utilised and incorporated into the personality.

Dr. Ernest Jones approaches the subject from a view-point according closely with that of Freud. Unconscious material is characterised by the "resistance" which is displayed when an attempt is made to render it conscious, and by the fact that its content is of such a nature as to be in sharp conflict with the tendencies and attitude of the conscious mind. While Dr. Rivers would say that unconscious is dissociated because it is "detrimental to welfare," incompatible with reason. Dr. Jones regards the process as hedonic rather than utilitarian in nature; it is unconscious because it is unpleasant to the conscious personality. The "unconscious" is unconscious because of the inhibiting pressure of the affective factors grouped under the name "repression." These affective factors develop with mental growth, and inhibit and repress infantile impulses which are perfectly natural in the early stages of life. In early life the primitive pleasure-pain principle dominates the reactions of the organism; with mental development the "reality-principle," *i.e.*, the subordination of immediate pleasure or avoidance of pain to the exigencies of objective reality, supplants the pleasure-pain principle. The primitive infantile impulses thus acquire an unpleasant feeling-tone and constitute the unconscious; they undergo repression as a result of their increasing incompatibility with the conscious mental life.

H. DEVINE.

## 2. Clinical Neurology and Psychiatry.

- (1) *A Personality Study of the Epileptic Constitution.* (*Amer. Journ. Med. Sci.*, 1914, c. xlvii.) *Pierce, Clark L.*
- (2) *The Psychological and Therapeutic Value of Mental Content During and Following Epileptic Attacks.* (*New York Med. Journ.*, October 13th, 1917.) *Pierce, Clark L.*
- (3) *Clinical Studies in Epilepsy.* (*Psychiatric Bulletin*, January, 1916, to January, 1917.) *Pierce, Clark L.*
- (4) *A Further Study of Mental Content in Epilepsy.* (*Psychiatric Bulletin*, October, 1917.) *Pierce, Clark L.*
- (5) *The True Epileptic.* (*New York Med. Journ.*, May 4th, 1918.) *Pierce, Clark L.*

The researches contained in the above series of papers indicate a promising line of study, which should lead not only to a greater insight into the nature of epilepsy, but also suggest directions into which mental therapy may be usefully applied. For some time a marked reaction against the purely drug treatment of epilepsy has become manifest. The establishment of colonies for the segregation of epileptics, together with a more rational form of therapy, diet, hydrotherapy, and detailed plans of work and exercise, indicate a recognition of a more individual and psychological method of treatment, and of the necessity of creating an environment to which the epileptic can make a useful adjustment. These researches suggest that a still more intensive individual treatment is possible, and they indicate an effort to introduce a rational psychologic therapy for epileptic conditions founded on essential defects in the make-up of the epileptic constitution.

An understanding of this problem can only be gained by a study of the primary and fundamental make-up of the epileptic which antedates the grosser epileptic manifestations for years. The usual make-up of the potential epileptic child is one of ego-centricity, emotional poverty, morbid sensitiveness, and an inability to take on the adaptive social training in the home and school. Such a type in contact with an exacting environment expresses itself in rages and tantrums, which expressions of mal-adaption should be side-tracked by directing the interest to another channel. In these exhibitions of baulked desire the child's psychic activity must be regarded as a continuously outflowing stream of interest, unfortunately thwarted, which should not be dammed or blocked, but should be re-directed by individual approach and painstaking attempts to create an atmosphere to which the defective child can make a satisfactory adjustment.

The main epileptic defect is an inheritable one. There is an attenuated desire to reach out into the external world, and the social instinct is soon withdrawn, and becomes centered on the epileptic producing the classic ego-centric make-up, with its peculiar character distortion. This early repression of emotion not only results in failure of social contact, but hinders intellectual development, leading to new stresses and humiliations. The ego-centricity is not a lack of emotional feeling, but it is feeling wrongly directed leading to increased sensitiveness. The effects of a stressful environment on such a temperament



inherently inadaptably to normal social life are seen in the regressive tendencies of day-dreaming, lethargies, somnolence, and, later on, definite epileptic reactions. The last occur as a final outbreak of a too severe tension, and psychologically may be viewed as an intense reaction away from an intolerable situation—a regression to a primitive mentality comparable to that of infancy or intrauterine life. The fit is thus a kind of emotional cathartic, the sting of the previous stress is removed, and annoying incidents are but half remembered, the amnesia acting as a kind of protective curtain.

Therapy in essential epilepsy should concern itself especially with the eradication, as far as possible, of the defective instincts shown in egocentricity, supersensitiveness, and rigidity of adaption to the home and community. This is best brought about by a reduction of environmental stress, educating the child in adaption to the various types of stress and the search for a spontaneous outlet for his keen individualistic desires, and the creation of his own interests in a healthful environment. Since these individuals with this defective make-up tend to show pronounced epileptic manifestations whenever they fail to make proper life adaptations, the fit is to be regarded both a regressive as well as a protective phenomenon—a reaction away from stressful reality.

In order, therefore, to obtain indications for therapeutic training, it is important to obtain some knowledge of the epileptic mental content in twilight states or post-epileptic conditions, in so far as this reveals the intimate part of his unconscious strivings, and furnishes insight into his humiliations and conflicts. In obtaining mental content, three main divisions of psychic events are to be considered: (1) The remote or immediate stresses that promote and aggravate the occurrence of individual epileptic reactions; (2) the actual mental content obtained in the specific attack; (3) the early or ultimate free association upon the material expressed in the content. Proceeding on these lines, the writer furnishes details of his investigations upon a number of cases, and he proves that the epileptic regresses from the displeasurable difficulties of life, and that in the first stage of the fit the stress alone may be discerned, but that when the patient reaches a deeper unconscious state he gains the level of an easily recognisable sexual striving. The basic idea in such studies is to determine the defective make-up and its specific conflicts, to bring into the patient's mind a better insight into his malady, and then cause him to see the consequence of his crude handling of life. A knowledge of the epileptic content furnishes a specific point of analytic attack by simple explanatory talks, and indicates more definitely the type of special education which should be adopted for each individual patient.

The task of rehabilitating such epileptics is extremely difficult because of the depths of unconscious regression taken, and the extreme infantilism of the instinctive trends brought out. Such investigations, however, enable them to make the best use of their lives, and while, of course, there can be no change in the facts of life, talking over difficulties gives much relief—it gives a new view-point, and shows the patient that there are other ways of reacting to unpleasant stresses.

H. DEVINE.

*Psychoses associated with Influenza.* (*The Journal of the American Medical Association*, January 25th, 1919.) *Menninger, Karl A.*

The cases upon which this study is based were observed at the Boston Psychopathic Hospital during the recent epidemic. One hundred cases of mental disturbance associated with influenza were admitted during a period of three months, eighty of whom were intensively studied. The cases are divided into four groups: (1) Infection-toxin delirium, prefebrile, febrile, and post-febrile; (2) dementia præcox; (3) other psychoses, manic-depressive insanity, psycho-neurosis, paranoia, alcoholic psychoses, and neurosyphilitic psychoses; (4) unclassified. It was found that in all but the febrile deliria there was usually an interval of from two to eight days from the termination of the influenza and the first manifestations of the psychosis.

The writer suggests that these observations furnish some evidence for the organic basis of dementia præcox. The facts on which this view is based are: (1) The frequency of its occurrence (31 per cent.) in this series; (2) the tendency of the cases between the ages of 20 and 30 to develop this form of disorder; (3) the frequency of schizophrenic symptoms in otherwise typical cases of delirium; (4) the occurrence of several cases in which a diagnosis could not be made between delirium and dementia præcox. The psychiatric prognosis in influenza, excluding cases with a previous psychotic basis, such as alcohol and neurosyphilis, may be expressed in general as delirium (with recovery), death, or dementia præcox.

H. DEVINE.

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*The Treatment of Delirium Tremens by Spinal Puncture, Stimulation, and the Use of Alkali Agents.* (*Journ. of Nerv. and Ment. Dis.*, February, 1918.) *Hoppe, H. H.*

The method of treatment here outlined is based upon the pathology of the disease. Delirium tremens is an acute exhaustion psychosis developed upon a basis of chronic alcoholism. There are thus the characteristic pathological changes in the brain, heart and blood-vessels, the result of chronic alcoholism, and also an acute condition of the meninges caused by a poison which has found its way into the cerebral circulation. Degenerative changes and passive congestion of the intestinal tract lead to the formation of an intermediate toxin, which is probably the cause of the delirium. As long as this toxin can be eliminated by the kidneys, with the help of the circulatory apparatus, conditions are fairly normal. As soon as there is a failure of elimination, however, cerebral oedema, an increase of cerebro-spinal fluid, arterial ganglionic cell asphyxia, acidosis, and then delirium tremens occur. The underlying causal factors, the toxin, weakened circulation, deficient elimination, increased pressure of the cerebro-spinal fluid are therefore rationally treated by elimination, stimulation of the circulatory apparatus, and the removal of the increased pressure on the brain and cerebral circulation.

Briefly, the routine method adopted is as follows: (1) Catharsis—calomel and Epsom salts; (2) digitalis and nux vomica; (3) alkalies; (4) hot packs; (5) spinal puncture—from 30–60 c.c. being withdraw

As a result of considerable experience of treatment upon these lines the writer concludes that the disease is thereby rendered shorter and milder, the patients are easier to nurse, complications are avoided, and the death-rate is definitely reduced.

H. DEVINE.

## Part IV.—Notes and News.

### THE MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

THE QUARTERLY MEETING of the Association was held at 11, Chandos Street, Cavendish Square, London, W., on Thursday, February 20th, Lieut.-Col. John Keay, M.D., F.R.C.P., R.A.M.C. (President), in the chair.

The following signed their names in the book as having been present at the meeting or as having attended meetings of committees: Sir G. H. Savage, Sir Robert Armstrong-Jones, Drs. M. A. Archdale, G. F. Barham, Fletcher Beach, Charles H. Bond, David Bower, A. N. Boycott, James Chambers, R. H. Cole, M. A. Collins, Maurice Craig, Alfred W. Daniel, H. Devine, J. Francis Dixon, R. Eager, Claude F. Fothergill, R. W. Dale Hewson, G. H. Johnston, H. Kerr, A. C. King-Turner, R. L. Langdon-Down, S. Rutherford Macphail, John Marnan, W. F. Menzies, Alfred Miller, Hubert J. Norman, David Ogilvy, E. S. Pasmore, Bedford Pierce, Daniel F. Rambaut, Charles Stanford Read, David Rice, Marriott L. Rowan, J. Noel Sergeant, Edward B. Sherlock, G. E. Shuttleworth, Thomas W. Smith, J. G. Soutar, T. E. K. Stansfield, R. C. Stewart, W. H. B. Stoddart, F. R. P. Taylor, John Turner, C. M. Tuke, James R. Whitwell, H. Wolseley-Lewis, Reginald Worth, and R. H. Steen (General Secretary).

*Present at Council Meeting:* Lieut.-Col. John Keay (President) in the chair, Sir R. Armstrong-Jones, and Drs. David Bower, James Chambers, R. H. Cole, A. W. Daniel, R. Eager, Alfred Miller, Bedford Pierce, J. Noel Sergeant, G. E. Shuttleworth, H. Wolseley-Lewis, and R. H. Steen.

Drs. S. Rutherford Macphail, J. G. Soutar, T. E. K. Stansfield and R. Worth were present by special invitation.

Apologies for unavoidable absence were received from: Drs. T. S. Adair, H. D. M. Alexander, G. N. Bartlett, R. B. Campbell, Maurice Craig, Arthur N. Davis, Thomas Drapes, J. R. Gilmour, G. D. McRae, J. Mills, L. R. Oswald, Donald Ross, E. F. Sall, James H. Skeen, J. B. Spence, H. F. Stephens, Francis Sutherland, and D. G. Thomson.

The minutes of the last Quarterly Meeting, having already been printed in the Journal, were taken as read and signed.

#### OBITUARY.

The PRESIDENT said that since the last meeting of the Association the death had occurred of one of the past Presidents, Dr. George William Mould, the Medical Superintendent of the Manchester Mental Hospital at Cheadle. Dr. Mould was a very old member of this Association. He graduated in 1858, and then was appointed to the post of Resident Medical Officer at Prestwich Asylum. While there he received the transfer to the Medical Superintendentship of the Royal Mental Hospital, Cheadle. Dr. Mould was Lecturer and Examiner in Mental Diseases at the Victoria University, Manchester, and in 1880 became President of this Association. He, the President, was sure it would be the wish of the meeting that the Secretary be instructed to forward a suitable letter of condolence to Dr. Mould's surviving relatives.

This was agreed to by members rising in their places.

The PRESIDENT said he wished next to refer to a personal matter. He was very sorry that illness prevented his attendance at the meeting held in London last November. At the same time he wished to express to members his thanks for the

letter of sympathy he received on their behalf from the General Secretary. Further, he desired to express his indebtedness to Colonel Thomson for taking his, Col. Keay's, place on that occasion.

#### GREETINGS FROM THE MEDICO-PSYCHOLOGICAL SOCIETY OF PARIS.

The PRESIDENT asked the Secretary to read a letter which had been received from the Medico-Psychological Society, Paris.

### SOCIÉTÉ MÉDICO-PSYCHOLOGIQUE.

#### SECRÉTARIAT GÉNÉRAL.

MONSIEUR LE PRÉSIDENT,—La Société Médico-Psychologique de Paris a tenu sa séance mensuelle le lundi 25 Novembre dernier. Sur la proposition de son Président, M. le Dr. Henri Colin, elle a voté l'ordre du jour suivant :

" La Société Médico-Psychologique, dans la joie de la victoire commune, adresse à sa soeur, l'Association Médico-Psychologique de la Grande-Bretagne et de l'Irlande, ses meilleurs souvenirs et ses vifs sentiments d'affectueuse sympathie ; elle émet le vœu que des liens d'une plus intime solidarité se nouent entre les deux compagnies savantes pour le plus grand bien de la Science et de l'Humanité."

Je suis heureux d'être chargé par mes collègues de vous envoyer cet ordre du jour, faible témoignage de notre sincère attachement et de notre vive admiration pour la Grande-Bretagne, cette noble Nation, qui a lutté vaillamment et noblement à côté de nous pour défendre la civilisation contre la barbarie.

Veillez agréer, Monsieur le Président, l'hommage de mes sentiments respectueuses et dévoués.

—Le Secrétaire Général,

PARIS ;

ANT. RITTI,

le 8 Décembre, 1918.

68, Boulevard Exelmans (XVI).

Monsieur le Président de l'Association Médico-Psychologique de la Grande-Bretagne et de l'Irlande.

The PRESIDENT said he was sure all members would reciprocate most cordially the desire of their sister society in Paris for closer relationships, and, therefore, that it would be the pleasure of those present to authorise a letter being sent expressive of their sentiments, also their never-dying admiration for their gallant comrades of France. The question arose as to the manner in which the closer relationships alluded to could be manifested. It might be suggested that this Association should invite representatives from the sister Society to attend the next annual meeting of the Association. He would be glad to hear views on the matter.

Dr. BEDFORD PIERCE moved that the President's suggestion be adopted, namely, an invitation be sent to the Paris Society to send representatives to the Association's next annual meeting.

This was agreed to.

#### RESIGNATION OF DR. STEEN AS SECRETARY.

The PRESIDENT said he presumed members were all aware that the General Secretary, Dr. Steen, had been advised to curtail his activities, hence he found it necessary to resign the office of Secretary of the Association. Dr. Steen had been a most admirable Secretary, possessed of energy, tact and wisdom, he had been a safe guide, and was always a most jealous guardian of the interests of the Society. It was fortunate that he was able to announce that Major Worth had expressed his willingness to take upon himself the burden which had been borne by Dr. Steen, and it should be left to the President to express the confident hope and expectation that he would be a worthy successor to Dr. Steen.

Dr. STEEN thanked the President for the very kind remarks he had made concerning him. At times the secretarial duties might seem rather heavy, but the other officers of the Association were so very helpful and kind, especially the Treasurer and the late Treasurer, that really the work had not been so very difficult after all, and it certainly was a great pleasure to work for the Association.



## ASYLUM ADMINISTRATION AS AFFECTED BY PRESENT EVENTS.

The PRESIDENT: Members have all received an addendum to the business of this meeting, in the form of a letter from the General Secretary, stating that he had been written to by several members to say that, in their opinion, the Association should discuss the question of asylum administration as affected by present events. It is suggested that that item of the business of the meeting should come on now, therefore I will call upon Dr. Wolseley Lewis to introduce the subject.

Dr. WOLSELEY LEWIS: You ask me, sir, to introduce a discussion on asylum administration as affected by present events, and I do so, not because I have a scheme for an asylum millenium in my pocket, but because I think it is a matter of paramount importance to this Association. The recent events alluded to are, firstly, the issue of the programme of the National Asylum Workers' Union; and, secondly, some conferences which have been held at the Guildhall and at the London County Hall recently, at which this programme, among other things, was discussed. I have had the advantage of studying the National Asylum Workers' programme, and also of having been present at both the conferences. Whether we view the National Asylum Workers' Union with sympathy or not, whether we approve of the nursing staff of an asylum being members of a trade union, whether we think it dignified, appropriate, or wise for them to join the Union appears to me to be chiefly a matter of academic interest. The fact is that they have formed a Union. The law allows, and public opinion approves of, the principle of collective bargaining. It is our business, I submit, to deal with the facts.

What are the facts? Firstly, a registered trade union has been formed by a considerable percentage of asylum staffs, and they have been trying to enforce their demands by strikes and threats of strikes. The ever-increasing demands of this Union have driven public authorities to unite in order that they might formulate some common policy to deal with the situation. The Executive Committee of the Guildhall Conference and of the Conference which was held at the London County Council Hall have written to the Ministry of Labour asking that ministry to set up an Industrial Board, composed of ten representatives of the public authorities and ten representatives of the National Asylum Workers' Union. And the delegates of the National Asylum Workers' Union who were present at the London County Council conference undertook to recommend to their executive committee that they would make a similar representation to the Ministry of Labour.

So much, then, Mr. President, for the facts. Now, there are two points to which I wish to draw your very particular attention. The first is, that the National Asylum Workers' Union claims to be representative of a highly-skilled body of workers. Is that claim well founded? They admit—nay, they induce to become members of the Union—any employee entering an asylum, however newly joined, however untrained, and whatever measure of responsibility he may have. On the other hand, they discourage, and I understand they exclude, an officer of any sort. It seems to me that that necessarily means that the preponderance of their members must be the comparatively irresponsible, those who know very little of the conditions of asylum life, and that their debates must necessarily lack the steadying and wiser counsels of those who, by longer service and by their ability, have raised themselves from the ranks. So that I ask again, Does the National Asylum Workers' Union really represent the skilled nursing employé of an asylum?

The second point to which I wish to draw your attention is this: There are many questions of asylum administration on which medical superintendents are asked to advise their committees. But under this Industrial Council the medical superintendents will have no representative on either side, and it seems to me, under such circumstances, that members of this Association will find themselves in a very anomalous position! Take, for instance, the first item on the Asylum Workers' Union programme. They ask for a 48-hour week. That is, by inference, an 8-hour day, or night, as the case may be. Obviously our first duty is to safeguard the interests and to promote the welfare of our patients by every means in our power. Recognising this, I have long been in sympathy with a reduction of the hours of the nursing staffs of asylums because I think it means improved efficiency. But please note that, when I say that, I essentially mean hours per day and not necessarily hours per week. It is the reduction of the working hours per day that I believe the more intelligent of the asylum staff wish to have, and

it is the reduction of the working hours per day which I think is likely to increase their efficiency. In other words, I do not think 12 or 14 hours a day make for efficiency. The war has taught us many things, and during our recent enforced shortage of staff I had an opportunity of observing that there were periods in the daily routine of a large asylum when a substantial reduction of staff might occur without detriment to the patients. And this observation led me to propose to my Committee a scheme which they have adopted and ordered to be put into execution as soon as possible. If you will allow me I will very shortly sketch that scheme. It is based on the old calculation of one attendant to ten patients, and presupposes that patients rise at 6 and are in bed by 8.

#### DR. H. WOLSELEY LEWIS'S SCHEME FOR HOURS OF DUTY OF NURSING STAFF.

*March, 1919.*

Allow 100 Attendants or Nurses for Day Duty for 1,000 beds (*i.e.*, 1 to 10).

Deduct 15 average number daily off duty.

" 6 " " on annual leave.

" 3 " " sick.

Leaving 76 on duty.

Half Staff to commence duty at 6 a.m. and leave at 6 p.m.

Half Staff to commence duty at 8 a.m. and leave at 8 p.m.

Change of hours to be made weekly.

Staff Breakfasts 8-8.30 and 8.30-9.

Staff Dinners 12.30-1.15 and 1.15-2.

Staff Teas 5-5.30 and 5.30-6.

Allow 20 Attendants or Nurses for Night Duty for 1,000 beds (*i.e.*, 1 to 50).

Deduct 3 average number nightly off duty.

Leaving 17 on duty.

(Other deductions allowed for in day duty numbers.)

Night Staff to commence duty at 7.45 p.m. and leave at 6 a.m.

Breakfast at 6.30 a.m.

Dinner at 7 p.m.

One meal during night in Ward Kitchens by arrangement among Staff.

Making a working day or night of 10½ hours, or 61½ hours per week.

#### KENT COUNTY ASYLUM, MAIDSTONE.

##### *Daily Routine.*

6 a.m. Patients get up and Day Staff takes over Wards.

6.30 Night Staff Breakfast.

7.30 Patients' Breakfast.

8-8.30 1st Staff Breakfast.

8.30-9 2nd Staff Breakfast.

9.15-12 Chapel.

Medical Officers' Visits.

Airing Courts.

General Bathroom.

12 noon Female Patients' Dinner.

12.15 Male Patients' Dinner.

12.30-1.15 1st Staff Dinner.

1.15-2 2nd Staff Dinner.

2-5 Airing Courts.

Walking Parties.

Shopping Parties.

Funerals.

General Bathroom.

Lectures.

Fire Drill (Thursdays).

Catholic Service (Fridays).

Choir Practice (Fridays).

Band Practices.

5 Patients' Tea.  
 5-5.30 1st Staff Tea.  
 5.30-6 2nd Staff Tea.  
           Medical Officers' Visits.  
           Entertainments.  
           Dances, etc.  
 7-7.30 Night Staff Dinner.  
 7-7.30 Patients go to bed.  
 7.45-8 Night Staff takes over Wards.

In working out the details of this scheme, I was very much impressed by the fact that I could find no way of materially reducing the hours below what I have said without sacrificing the patient. Of course, there is the three-shift system. My objections to the three-shift system are these: First, it means a constant change of *personnel*, and therefore a lack of continuity in the treatment of the patient. We all know what it means if the "charge" and the second in the ward are off duty. Those of you who have read your *Times* this morning will have seen that in the general London hospitals there is the same move to shorten hours, and I notice that in some hospitals they are proposing an 8-hour day. I submit, Sir, that the condition in asylums is rather different from that in a general hospital. I can quite understand that if you have a nurse who is, we will say, cognisant of the proper treatment of a fractured leg, the nurse-in-charge might be changed three times in 24 hours without any detriment to the patient. But in the case of mental disease, those of us who are acquainted with the working of an asylum know it is very important that the person in charge should have an opportunity of observing those slight alterations and gradations in a mental state from hour to hour. The second objection is that it means a difficulty in assigning responsibility in cases of neglect or improper treatment. Thirdly, there is a great difficulty in assigning responsibility for stock in the wards. Fourthly, it means a very large expenditure for the provision of the extra staff which would be required—I mean in housing. Fifthly, it means such a burden in the shape of wages that the ratepayer may well ask whether it is justifiable, especially when we come to remember that though the duties of the staff in an asylum are often very trying, and especially so in certain wards, they are not usually arduous, and such duties as attending dances or chapels or entertainments are certainly not so.

I have gone into this hours question at some length to show how complex it is, and how intimately it is bound up with the welfare of the patients. It was very noticeable that at the London County Council Conference the welfare of the patients and the nature of the relations between the staff and the patients was entirely ignored, and the hours question was discussed from a purely industrial standpoint—that is to say, simply a comparison between the hours in other trades unions and this, and not in any sense from that of the hours necessary for this particular work. It is probable that at the Industrial Board it is thus that this question will be decided, by bodies of men who have not the necessary knowledge, and who will not consider how their decisions will affect the proper care and treatment of the patients, such proper care and treatment being the only reason why the question ever arises. That, Sir, I think, is a very Gilbertian situation, and I think that is why this question is one of paramount importance to the Association. I am of opinion it is imperative that we should take immediate and definite action to place our views before any Industrial Board which may be set up, and that we should be prepared to put forward a considered policy on these very important questions.

If I am in order, Sir, I would like to move the following resolution: "That this Association, which has done much in the past to improve the treatment of the insane, in the event of the establishment of an Industrial Board, consisting of ten representatives of Asylum Authorities and ten representatives of the National Asylum Workers' Union, to decide conditions of service of the working staff of asylums, strongly urges at the same time the provision of a board of experienced asylum medical officers to indicate how such decisions would affect the welfare of the patients." And I would like to suggest, if I may, that such a resolution, if seconded and passed by this Association, shall be sent to the Ministry of Labour, to the Executive Committee of the Guildhall Conference,

to the London County Council, to the Board of Control, and to the Chairmen of the Visiting Committees of Borough and County Asylums and registered hospitals and the National Asylum Workers' Union.

Dr. SOUTAR: I second the resolution which Dr. Wolseley Lewis has moved. I do not propose to discuss the suggestions or the demands made by the Asylum Workers' Union. Our claim is that we, as representatives of the medical profession dealing especially with the insane, shall be represented on, and that our views shall be put before, any body which is considering matters concerning asylum administration. It is suggested that that body shall consist of representatives of managing committees of asylums and of representatives of the Asylum Workers' Union. These look at asylum administration from two points of view. But there is another—the most important of all—that is as to how decisions arrived at will affect the well-being of the patients. On this matter medical officers only can speak and advise with the authority which comes of knowledge. If they be excluded from the body which is to consider asylum administration no informed and effective advice will be available for securing that proposed changes in administration shall operate to the advantage of the patients, for whose well-being alone our asylums exist. There are committees and there are attendants who would be very glad to have the assistance and the support of asylum medical officers in their deliberations. There are attendants—and many of them—who have in them the true spirit of nursing, who recognise that they are not, like factory hands, merely industrial workers. That spirit—the nursing spirit of sacrifice and readiness to serve the sick—is active in many of our asylum nurses and attendants, and these deserve and require the support which can be fully given only by medical officers who are so closely in contact with them and with the persons to whom they minister. There are, too, many asylum committees who turn to their superintendents for advice and direction on these matters, asking how this and that proposal will affect the patients. Such committees would, I think, regret the absence of medical officers from a body to whom it fell to consider and decide upon matters of asylum administration. I urge that we should endeavour to secure due representation of the medical element on any body which is formed to deal with asylum administration, and that to this end, and that detailed consideration be given to the various matters raised both by managing committees and by the Asylum Workers' Union an advisory committee consisting of members of the Medico-Psychological Association be appointed. I have pleasure in seconding the resolution.

The PRESIDENT: We shall be glad to hear the views of members or of visitors upon this important matter; I notice there are visitors present.

Dr. PASMORE: I support the resolution which has been proposed by Dr. Wolseley Lewis and seconded by Dr. Soutar. The proposition is a very important one in getting representation on this Industrial Council of medical superintendents. Because what would happen is, that if we were getting men who were not in sympathy with the insane, the attitude they would take up towards the patients would be rather that of warder to convict, instead of that of nurse to patient. It is most important that this last attitude should be preserved. We know from books that in the past, when asylums were under lay control and administration, the attitude was nearer that of warder to convict than that of nurse to patient. Lay people, who do not understand the right treatment of the insane, speak of lunatics in a derogatory manner. The Asylum Workers' Union and the programme which they have promulgated has received the attention of several committees of the country. It received some attention at Croydon, but not very much. With reference to the hours, they have asked for 48 hours per week. I agree with Dr. Wolseley Lewis it is not feasible to work 48 hours a week, but we have been working a 66-hour week for the last two years, and I think a 60-hour week is very workable. What we do is this: The patients, instead of rising at 6, rise at 7, and the nurses and attendants go off duty at 7.45. And the nurses and attendants have two hours off during the day—an hour for dinner, half an hour for lunch, half an hour for dressing. A 60-hour week could be easily worked by giving the nurses and attendants a half-day on Saturday, the whole day Sunday, half a day Wednesday, and an evening in the week. I agree with Dr. Wolseley Lewis that you get much fatigue emanating from the present day, but where you break up the week, and have a break in the mid-week, that fatigue



would be lessened. For three years I had the opportunity of working in the Psychological Laboratory of University College, where we did much work on the subject of fatigue. We found that if, when a person reached a state of fatigue, he left off at once, he could recuperate in quite a short time; but if he continued for an hour after being fatigued, recuperation required a much longer time. If a man had done a reasonable amount of work by 5, but he went on until 7 o'clock, he would take, probably, four hours to recuperate. For that reason there is something to be said for a shorter day, if it can be arranged.

Dr. MILLER: I suggested before the meeting that there should be a time limit for each speaker except the introducer. I shall, myself, be very brief. I think it is right that it should be a *sine qua non* in the formation of these Whitley Committees that both sides should be organised. I do not think medical superintendents are going to be received on one side, and they cannot be received on the other. Manifestly, they are employes, and I do not think it is possible for them to get representation on these committees. For this reason they are out of court. I do not suppose we should be sitting on the same side of the table as the asylum workers in the Union, and we cannot be there as employers, because we are not employers. Therefore, it seems to me, we cannot get representation on them.

The PRESIDENT: The idea is that there would be advisory committees, composed of medical superintendents, who could be consulted.

Dr. DIXON: I suggest a slight amendment to the resolution—that we should say “That this Association, composed of medical men who are specialists in the treatment of mental diseases.” I think it is likely some of the asylum authorities do not know what the Medico-Psychological Association is at all, and I think it would strengthen the resolution if that little proviso were put in, showing that the Association is composed of medical men who are specialists in the treatment of mental diseases.

Dr. SOUTAR: In regard to the question of the value of this Advisory Committee, I think there is definite value in it, because it is clear that it is in the minds, at all events, of some Government departments to have Advisory Committees appointed. I heard Dr. Addison the other night speaking with regard to the appointment of Medical Advisory Committees, and he was evidently going to make great use of them. I think we might urge, in consideration of a matter of this kind, that an Advisory Committee might be appointed and at all events consulted, and there would at least be such a body in existence for the authorities to seek advice from. Some can, of course, become representative members of the proposed Board, and we can, at all events, announce that we are in existence, and that we are prepared to give advice and to express our opinion on the matter as it appears to us as medical superintendents of asylums. Even if we do not go further than that, we do take a step forward and establish our claim to be asked and consulted in regard to a matter upon which we have experience.

The PRESIDENT: If no one else wishes to speak, I will put the resolution reworded as follows:

“That, in the event of the establishment of an Industrial Council (consisting of ten representatives of Asylum Authorities and ten representatives of the National Asylum Workers' Union) to consider the conditions of service of the nursing staffs of asylums, this Association, which is composed of medical men actively engaged in the care and treatment of persons of unsound mind, strongly urges the provision of an advisory board of experienced medical officers of asylums to indicate how any alterations proposed would affect the welfare of the patients.”

The resolution was carried unanimously.

Dr. BEDFORD PIERCE: May I now introduce a kindred matter for the consideration of this meeting? It refers to the training of nurses and others engaged in the care and treatment of the insane. As we are all aware, this Association has worked hard at this subject for many years, yet we find in the proposals of the Asylum Workers' Union no reference to the training and no recognition of the trained nurse as opposed to the untrained or the imperfectly trained one. And I think that if we let this occasion go by without putting forward very plainly the importance of training in the interests of the insane—it is also important in the interests of the nurses themselves—it will be a mistake. They are not merely a lot of uneducated people, but people who have taken up a calling which requires training, a career which requires effort on their part to qualify for it. If we leave

this out, I think we shall be undoing a great deal of the work we have done in the past. If this training is ignored, very few in the future will take the trouble to train. Therefore I propose that we bring this subject before the various bodies who are dealing with this subject of conditions of service, and so I submit this resolution:

"The Medico-Psychological Association of Great Britain and Ireland wishes to lay stress upon the principle that the best interests of the insane demand the careful and systematic training of all persons engaged in the care and treatment of patients in mental hospitals.

"The Association strongly recommends that nurses who are well trained and duly qualified should receive considerably higher remuneration than those not so qualified."

Dr. MENZIES: May I second that? The way we have to bring it before the Asylums Workers' Union is that they be requested to recognise the contracts of apprenticeship.

Dr. TURNER: I gathered from the meeting at the London County Council that the Asylum Workers' Union not only do not recognise the Medico-Psychological Association, but they are under the impression that to be boxed up with the insane means becoming a qualified nurse, and that they are going to do away with all training. That is a very strong point.

Dr. DIXON: I attended this Conference, and I heard the delegates speak, and from what I gathered they seemed to think that as soon as a candidate became a nurse in an asylum she immediately became skilled—that a probationer on the first day became skilled—and apparently they wanted a minimum wage to be given to a junior employee as to a skilled worker. Of course, they very rightly made the point that it is a very sound thing to get a better class of worker to deal with the insane. They said if we want good treatment we must get a better class in to attend to patients, therefore we must give them shorter hours and do various other things. But they did not say, "Therefore we must train them." It is a matter of wages and short hours. They expect to get a good class of nurse. I do not agree with that. I think the less wages you pay, the better nurse you get. (Laughter.)

The resolution was carried.

Dr. BEDFORD PIERCE: I suggest that this be sent to the same people.

Dr. MACPHAIL: Do we accept the principle of forty-eight hours per week? Do we agree? And when we appoint this Committee from this Association, what are they going to say? What views will they bring before them? I ask whether we, as a society, accept the principle of working forty-eight hours per week?

Dr. STEEN: To answer Dr. Macphail, the Council have to-day decided to call a special meeting of the Association to consider all these questions at an early date.

Dr. TAYLOR: Am I in order in raising the question of the agenda of the meeting at the Mansion House with regard to the business Executive Officer? Dr. Wolseley Lewis alluded to it in his opening speech. It is a very important question. It appears it must be a medical administration, and I thought that possibly the Association would make some comment on the appointment of this proposed business Executive Officer. It seems to me to be an impossible position for the superintendent if such an officer is appointed.

The PRESIDENT: That point might be brought up for the special meeting which has just been announced by the Secretary.

[A paper was read by Lieut.-Col. E. P. Cathcart on "Psychic Secretion—the Influence of the Environment." We regret that limitations of space will not permit of its appearing in this number of the Journal. It will, however, be published in our July number, along with the discussion which followed.—Eds., *Journal of Mental Science*.]

#### MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

At a Special Meeting of the Association, which was held at 11, Chandos Street, Cavendish Square, London, W., on March 13th, 1919, the following resolutions affecting asylum administration were passed unanimously:

LXV.

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(1) Proposed by Dr. Soutar and seconded by Dr. David Bower—"Resolved that to deny any asylum authority the discretionary power to appoint a medical officer as its representative on the National Council of Institutions for the Treatment of the Mentally Afflicted is inimical to the best interests of the patients, in whose treatment and care there often arise questions in which administration and medical considerations are so inextricably involved that the special knowledge and experience of the medical officers are essential for the proper understanding of such matters, and that a copy of this resolution be sent to the Provisional Secretary of the National Council of Institutions for the Treatment and Care of the Mentally Afflicted, and to all asylum authorities in England and Wales."

(2) Proposed by Dr. Turner and seconded by Dr. Turnbull—"That whilst this Association is in sympathy with reducing the hours of work so far as possible for the asylum nursing staff, it is opposed to the principle of a uniform standard of hours of work per week with payment for overtime as contrary to the ethics of the nursing profession."

(3) Proposed by Dr. Steen and seconded by Dr. Robertson—"That a special committee be formed to watch all movements of asylum management, and to be a general advisory committee to be appointed by the chairman, treasurer, and general secretary, together with the chairmen of the Educational and Parliamentary Committees."

(4) Proposed by Dr. Rice and seconded by Dr. Robertson—"That it be an instruction to the above committee that the fact be constantly pressed upon the Ministry of Labour and any industrial council formed to deal with asylum service, that the National Asylum Workers' Union is not truly representative of asylum workers, since it debars from membership all officers, whilst admitting domestic workers, artisans, and the most junior probationers, and makes no distinction between the trained and certificated, and the untrained."

*Preliminary announcement:* The annual meeting will be held at York on July 22nd and 23rd, 1919. Council meeting on July 21st, 1919.

#### IRISH MEETING.

THE SPRING MEETING of the Irish Division was held on Thursday, April 3rd, at St. Edmondsbury, Lucan, by the invitation of Dr. Leeper.

*Members present.*—J. M. Colles, K.C., LL.D., Lieut.-Col. Dawson, Dr. J. O'C. Donelan, Dr. Greene, Dr. Mills, Dr. O'Mara, Dr. Rainsford, Dr. H. R. C. Rutherford, and Dr. Leeper (Hon. Sec.).

Letters and telegrams of apology for unavoidable absence were read from Lieut.-Col. Keay (President of the Association), Dr. Nolan (Downpatrick), Dr. Drapes, Dr. Hetherington, Dr. Lawless, Dr. Revington, Dr. Redington, Dr. Harvey, Dr. Fitzgerald (Clonmel), Dr. Irwin (Limerick), Dr. H. Eustace, Dr. Gavin, Dr. Considine.

Dr. Colles having been moved to the chair, the minutes of the previous meeting were read and signed.

A ballot was next taken for election of the Hon. Secretary and two representative members of Council for ensuing year.

Dr. Mills and Dr. O'Mara having been appointed scrutineers, the Chairman declared that Dr. Leeper was elected Hon. Secretary; Dr. Nolan, District Asylum, Downpatrick, and Dr. J. O'C. Donelan were elected representative members of Council.

A ballot was next taken for election of two ordinary members of the Association. Dr. John Murnane and Dr. Stanley Blake were declared elected.

It was decided to hold the Summer Meeting at Ennis Asylum by the kind invitation of Dr. O'Mara.

The following dates were provisionally fixed for the meetings of the Division for the ensuing year: Autumn Meeting, Thursday, November 6th, 1919; Spring Meeting, Thursday, April 1st, 1920; Summer Meeting, Thursday, July 1st, 1920.

Dr. J. O'C. Donelan and Dr. Gavin were elected to the posts of Examiners for the certificate of the Association for the year.

The HON. SECRETARY stated to the meeting that the Royal College of Physicians had invited two delegates from the Irish Division of the Association to form part

of a deputation to the Chief Secretary for Ireland regarding the Ministry of Health Bill and its extension to Ireland. As the time given was so short he had secured the help of Dr. Nolan, who was very interested and fully informed with respect to all matters in connection with the subject, and he and Dr. Nolan had acted as delegates from the Division, and formed part of the deputation to the Chief Secretary. The Hon. Secretary then read to the meeting the statement handed in on behalf of the Division as part of the deputation.

*Statement to the Chief Secretary for Ireland, March 24th, 1919.*

"As representing the Irish Division of the Medico-Psychological Association of Great Britain and Ireland, we notice that in Sub-Clause 1 of the Clause of Ministry of Health Bill extending the same to Ireland the duty is laid on the Chief Secretary *inter alia* to take measures for the treatment of mental defects. We also notice that on the proposed Irish Public Health Council there is no representative of the Irish Asylum Service. We are strongly of opinion that no such measure should be undertaken without full consultation with the Irish Lunacy Department, without prejudice to the independence of the latter as a department, the powers of which should in our opinion be amplified in any event."

It was proposed by Dr. Mills, seconded by Dr. O'Mara, and passed unanimously: "That the action of Dr. Leeper and Dr. Nolan in acting as delegates by attending the deputation to the Chief Secretary and submitting the views, as stated, of the members of the Irish Division, be cordially approved of."

The meeting next proceeded to discuss this important matter, and the following resolution was proposed by Dr. Rainsford, seconded by Dr. O'Mara, and passed unanimously, and the Hon. Secretary was directed to forward same to the Lord Chancellor of Ireland, the Chief Secretary, the Attorney-General for Ireland, Sir Edward Carson, M.P., Sir Robert Woods, M.P., J. Devlin, M.P., Sir Maurice Dockrell, M.P., the Inspectors of Asylums, and to the Secretary, Parliamentary Committee of the Medico-Psychological Association, with the request that Dr. Cole would give it all possible support.

*Resolution.*

"That the Irish Division of the Medico-Psychological Association, having read the Clause of the Ministry of Health Bill, in which the treatment of mental defects is mentioned as one of the objects of that measure, respectfully suggests that in the appointment of an Irish Public Health Council due representation should be given on that Council to that branch of the profession specially concerned with the treatment of insanity in Ireland."

A vote of thanks to Dr. Leeper for his having entertained the Division terminated the proceedings.

REPORT FOR THE YEAR 1917 FROM THE LUNACY DIVISION, EGYPT, BEING THE TWENTY-THIRD ANNUAL REPORT ON THE GOVERNMENT ASYLUM AT ABBASIYA, AND THE SIXTH ANNUAL REPORT ON THE ASYLUM AT KHANKA.

THIS Report again provides ample material for full consideration. As usual Dr. Warnock's Report is a model of what such reports should be. It really represents, or is equivalent to, the Report of our Board of Control. It is divided into two parts, one concerned with the central establishment at Cairo, the other with the branch at Khanka.

Again we notice that there is great need for other asylums, the present ones being crowded, and the criminal lunatics being also retained in the general asylum.

The Report is a complete record not only of the medical but also of the financial sides of the lunacy work in Egypt. Beside the general Egyptian lunacy a considerable amount of work has had to be done in consequence of the war. Dr. Warnock established a special hospital for all the military cases occurring in officers connected with the British contingent.

Many points of special interest are reviewed, to which we shall refer in detail: for example, the serious effects of pellagra, and the different class of patients received into the central asylum and in the country one.



During the year Dr. Warnock had a short but much-needed holiday, during which time Dr. Dudgeon very efficiently took over the work. Dr. Dudgeon has special work, and under particular and trying conditions. He is away from Cairo, with difficult approach; he has to develop a kind of farming annexe to provide to a great extent the two establishments with vegetables. He, too, is overcrowded, and has no facilities as to water and electric supply. He has faced and mastered his difficulties. Later we shall refer to his special Report.

It is not easy to consider the Report as a whole because of the alteration of the date of issue, which is made to fit in with the financial year. The Report, therefore, covers the period from January 1st to March 30th, 1917, and from March, 1917, to March, 1918. It will suffice, however, to consider the full Report more in detail.

The number of patients in residence has risen from 2,104 to 2,118. There is accommodation in the two asylums for 1,550. The excess in residence at the time of the Report was 568. There were 1,062 Egyptian admissions during the year and 125 soldiers were received in the special hospital, the admissions being 1,062 and 1,219 for the years 1917 and 1918 respectively. The increase of admissions is partly due to the fact that more insane patients are now sent direct to the asylums instead of being detained in local general hospitals, pellagra being chiefly a disease met with among the fellahin; and as these patients are now more freely sent to the Khanka Asylum, this contributes considerably to the increase of admissions to that asylum. Patients are now taken to the asylum by private motor; this obviates the troubles which used to arise when they were taken by public conveyances. The war has prevented the building extensions needed for female patients, and it has also prevented the repatriation of European lunatics. It is essential that other asylums should be built—one certainly at or near Alexandria.

Regarding discharges, of 672 Egyptian cases 112 were recovered, 23 were found not insane on admission, and 537 were handed over to their friends, being, though still insane, no longer dangerous. They were discharged in order to make room for more urgent cases. This, as we have often pointed out elsewhere, is one of the serious results of deficient accommodation. Many of these patients are re-admitted with relapse, or else as criminal lunatics.

The death-rate at both establishments is very high; but this is accounted for to a certain extent by the retention of patients at home as long as the friends can manage with them at all, as there is still a considerable though decreasing dread of an asylum. The second cause of the increase of deaths is the number of chronic aged cases that have slowly accumulated at Abbasiya. Certainly there is a need for a large asylum or hospital for chronic or mentally-defective patients, as well as one for criminal lunatics. But, as Lord Cromer expressed to the writer of this review some years ago, lunacy legislation must wait on finance. The large death-rate at Khanka led to a consideration of the causes, and among these it was decided that the diet of the patients was insufficient, especially for the patients at this asylum, many of whom are occupied pretty fully on the farm. The subject of diet was referred to Prof. Wilson at the Department of Public Health. It was found that the native cheese, which formed an important article in the diet, was almost valueless. Accordingly the diet was considerably changed, several additions being made to it, and the improvement in the health of the patients and the reduction of the death-rate was considerable.

The contrast of the death-rate between the pauper patients and the paying class was very marked, the diet here again having an important influence.

The details as to building repairs do not need notice in this review, but we may say that as usual they are most complete, and, for the administering superintendent, very interesting. It is hoped to make a better provision for the Egyptian medical officers, some of whom have spent many years in the asylum, and many of whom have to live either in Cairo or in inadequate quarters.

General practitioners in Egypt are even more given to make mistakes in preparing certificates than are their English brothers, and these general practitioners have a pleasantly calm way of sending troublesome or dangerous patients to the asylum uncertified. A good number of patients who were not insane were sent to the asylum and several who were only delirious and suffering from fever.

The relative cost of maintenance, which is given in Turkish currency, is very similar to that in England.

Kindly reference is made by Dr. Warnock to the admirable work which was done by Lord Cromer when he was in Egypt.

In Part II of the Report a short account of the special hospital which was prepared for the Expeditionary Force is given. The patients as a rule were only resident here for a short time—in fact, till they could be repatriated. During the year 126 patients were admitted, and of all, 132 were discharged. No deaths and no accidents occurred there. At present more of the military cases are sent direct to the Citadel Hospital, thus relieving considerably the stress upon the temporary hospital which Dr. Warnock had prepared. Of the admissions to this hospital 25 were suffering from dementia præcox, 19 from delusional insanity, only 4 from general paralysis; 16 suffered from melancholia and 10 from mania. Other forms of insanity were also represented, but the number of cases of dementia præcox and of feeble-mindedness was certainly most remarkable, pointing to the fact that a very large number of thoroughly unsuitable soldiers were enlisted. Shell-shock was hardly represented by any of the cases admitted. As to attributed causes and relapses, conditions of military service and congenital defect were most marked. Forty-six of the 114 insane soldiers were said to have insane heredity.

Part III contains the special Report of the Abbasiya hospital, and is very full of medical and social interest. The cost of each patient works out at about 12s. 7½d. a week. Baskets and mats were made in large quantities by the patients. The utmost care was taken in regard to the general sanitation of the institution. A daily milk analysis was made, and photography was carried out also in relationship with all patients by the dispenser.

A more satisfactory system of drainage has been started.

There are now three grades of paying patients, and this adaptation for paying patients is answering well. Fourteen patients who had been prematurely discharged were re-admitted as offenders.

An analysis of the forms of insanity of the 72 male and 8 female patients admitted as accused of crime is given. This shows that pellagra was the most common attributed cause. Chronic dementia came next, but beyond pellagra nothing special is noteworthy as to causation of criminal lunacy. Thefts were the most common faults, but assaults and murderous attacks were rather common.

Of the general admissions to the parent asylum, pellagra is given as the most common associated cause. There were under care during the year, 2,367. Of these, 99 Egyptian patients were discharged well, 446 relieved. Pellagrous insanity produced 121, general paralysis 58, hashish produced 19. It is interesting to note that, on the whole, the number of general paralytics was considerable, being 58—47 male, 11 female—this proportion of female general paralytics being greatly in excess of what occurs most commonly in England. In the country asylum very few general paralytics were received. Over 10½ per cent. of the male patients admitted into Abbasiya were general paralytics. Pellagra accounts for nearly 23 per cent. of the female admissions, and nearly 32 per cent. of the female deaths.

Tables, of local interest only, are given as to the relationship of pellagra, hashish, and alcohol to the residence of the patients admitted. Of course, as already said, general paralysis and alcohol are much more commonly met with in town dwellers than in those admitted from the country districts, whereas pellagrous patients came chiefly from the country districts.

The great increase of mortality in 1917 is difficult to explain, but the following considerations throw some light on the matter. The number of female pellagrants admitted rose from 59 in 1916 to 73 in 1917. Another cause was the over-crowding of the harem. The increased number of deaths of lunatics admitted suffering from senile decay and advanced heart disease also was noteworthy. The increase of 16 male deaths in 1917, as compared with 1916, is partly explained by the increased deaths of general paralytics—49 against 39 in 1916. An analysis of the deaths is given, and one may say that *post-mortems* were not infrequently made. Most of the tubercular cases had evidently become infected while resident in the asylum in consequence of the overcrowding. Artificial feeding by the stomach-tube was performed frequently. Seclusion, of course, had also to be adopted.

The list of doses of hypnotics given is interesting, there having been during the year 6,775 doses of hypnotics used at night. This seems to me certainly not excessive.

No successful attempt at suicide occurred. Scabies was epidemic for a time.

Of the patients admitted, 8 had cut throats. In all, 54 *post-mortem* examinations were made.

Very good and useful work was done by the laboratory. The services of a medical officer were available for four months; during the rest of the year the work was done, in intervals from clinical work, by the rest of the staff. 408 stools were examined, and 57 were found to contain ankylostoma and ankylostomatous eggs. Many contained ova of other worms, and a few revealed bilharzia. 734 specimens of blood were taken and sent to the Department of Public Health Laboratory for Wassermann test. Thirteen specimens of sputum were examined for tubercle bacilli, 5 being positive. The results regarding the bilharzia examinations were interesting, and details are given of the special results.

A table is included giving the statistics of 625 cases of insanity admitted to which the Wassermann test was applied. Thus a large number of cases suffering from insanity of all forms were subjected to this process, and it seems to me that it is worth while to reproduce this table.

Diseases.	Total number tested.			Positive cases.			Percentage of positive cases.		
	Males.	Fem.	Total.	Males.	Fem.	Total.	Males.	Fem.	Total.
G.P.I. . . . .	36	9	45	28	9	37	77	100	88
Pellagra . . . . .	50	46	96	17	10	27	34	21	27
Adolescent insanity . . . . .	47	14	61	11	4	15	23	28	30
Mania . . . . .	61	63	124	14	17	31	23	27	25
Chronic dementia . . . . .	55	18	73	12	6	18	22	33	27
Hashish insanity . . . . .	10	—	10	1	—	1	10	—	10
Weakmindedness and imbecility . . . . .	33	9	42	6	3	9	18	33	25
Alcoholism . . . . .	29	4	33	4	4	8	14	100	70
Puerperal insanity . . . . .	—	8	8	—	2	2	—	25	25
Melancholia . . . . .	31	36	67	7	8	15	22	22	22
Post-febrile delirium . . . . .	2	—	2	1	—	1	50	—	50
Senile insanity . . . . .	13	10	23	2	3	5	15	30	22
Epilepsy . . . . .	10	9	19	—	3	3	—	33	16
Paranoia . . . . .	13	—	13	2	—	2	15	—	15
Organic dementia . . . . .	2	2	4	—	—	—	—	—	—
Delusional insanity . . . . .	3	1	4	1	—	1	33	—	25
Confusional insanity . . . . .	1	—	1	1	—	1	100	—	100
Total . . . . .	396	229	625	107	69	176	27	30	28

Thus there is evidence of the admirable work carried out by Dr. Warnock, both from the practical and scientific points of view.

We must make a special note of some of the work which was done by Dr. Dudgeon.

At the Khanka Asylum there is accommodation for 400 patients. They received 700, many of whom were direct admissions not passing through the parent institution. There were considerable difficulties in reference both to fuel and food. The admission number during the year was 266, the total number in residence during the year being 956. The death-rate, 134, was very high. This has been already referred to in reference to the imperfect diet, and also to the serious condition in which many of the patients were admitted. Again reference is made to the excess of fellahin among the patients, also to the very large proportion of patients suffering from pellagra. Hashish also produced a much larger number of patients in this asylum than in the parent one. There were, as we have already said, only three cases of general paralysis, and in all these there was

a positive Wassermann reaction. In the cases admitted to Khanka, alcohol and hashish were more common than in Abbasiya.

Elaborate notes are given of the general medical and surgical cases under notice. Particulars are given of the operations and the surgical lesions, many of which were of a trivial nature. There is a very careful and ingenious diagram dealing with the death-rate in the asylum. Unfortunately at Khanka there is no mortuary, and there are many other things required besides a great extension, which will have to be made as soon as possible. Among the recent patients admitted the recovery-rate was high. No mechanical restraint was used, and the employment of narcotics was much reduced.

Among other collateral products was the cultivation of henbane, also of guinea-pigs for the public institutions in Cairo. Altogether this Report by Dr. Dudgeon is a very satisfactory one.

Besides the Report already noticed, there are a series of statistics referring to the shorter period already alluded to, *i.e.*, three months before the statutory year commenced; but there is nothing essentially different in that report from the one to which attention has been drawn.

The Report concludes with an appendix, giving the medico-legal instructions, but these do not really interest the English reader of the Journal. Asylum diets are also given, but in that respect also the Report is so peculiarly local that it does not seem necessary to go into it.

We can only conclude this review by saying that, once more, it bears out what has been evident so long—that in the hands of Dr. Warnock the treatment of the insane is being most efficiently carried out under very arduous and trying conditions.

#### CORRESPONDENCE.

##### ENQUÊTE DE LA LIGUE POLONAISE DE L'ENSEIGNEMENT SUR LES ENFANTS ANORMAUX.

*To the Editors of the JOURNAL OF MENTAL SCIENCE.*

MONSIEUR,—J'ai l'honneur d'attirer votre bienveillante attention sur l'enquête organisée par notre *Ligue* et dont les résultats pourront être du plus haut intérêt pour l'organisation des Écoles en Pologne.

- (1) Historique de l'École ou de l'Institut consacré à l'éducation des enfants anormaux. Organisation. Initiative (privée ou publique). Nombre d'enfants.
- (2) Provenance des enfants et mode de recrutement.
- (3) Description des principaux types d'anormaux se trouvant à l'école.
- (4) La façon dont ils sont classés par l'instituteur ou l'institutrice pour les besoins de l'enseignement.
- (5) En quoi consiste l'instruction donnée aux anormaux et arriérés ?
- (6) En quoi consiste leur éducation ?
- (7) Procédés employés par l'école pour adapter les enfants à la vie.
- (8) Education morale. Moyens de discipline.
- (9) Les méthodes générales d'enseignement et les méthodes particulières (la lecture, l'écriture, le calcul, les travaux manuels, etc.).
- (10) Les exercices des sens et de l'intelligence.
- (11) L'éducation physique.
- (12) En quoi consiste l'inspection et le traitement médical ?
- (13) Quel pourcentage d'enfants arrive à passer dans les classes pour normaux ? Quel pourcentage arrive à gagner leur vie ? Quel pourcentage reste des non-valeurs ?
- (14) L'avenir de l'éducation des anormaux après la guerre. La nécessité de cet enseignement ne va-t-elle pas grandir ?
- (15) Prière de nous indiquer :
  - (1) Quelques données bibliographiques concernant le développement de l'éducation des anormaux dans votre pays.
  - (2) Quelques adresses des meilleures écoles pour enfants anormaux dans votre pays.

Prière de vouloir bien envoyer les réponses avant le 1<sup>er</sup> mars, 1919, à Mlle. M.



Grzegorzewska, secrétaire de la Ligue polonaise de l'enseignement, 8, Rue Monge, Paris 5<sup>e</sup>.

Dans l'espoir que vous voudrez bien collaborer à notre œuvre, je vous prie d'agréer, Monsieur, l'assurance de mes sentiments les plus distingués.

MARIE GRZEGORZEWSKA.

PARIS;

*Janvier, 1919.*

[Replies to the queries in above letter are solicited, and should be sent to Dr. Boulenger, Darent Industrial Colony, Dartford, Kent.]

#### RETIREMENT OF DR. SOUTAR.

Dr. Soutar's resignation of the position of Medical Superintendent at Barnwood House has evoked expressions of appreciation of his work there which must be very gratifying to him, and in which we wish to join.

Possessing in an unusual degree the qualities which characterise the ideal medical superintendent, and having had the advantage of being trained by an able and inspiring chief, Dr. Soutar was elected in 1892 to the position which he has recently relinquished.

That the confident hopes which were then expressed regarding his future career have been fully realised is evidenced by the terms in which the Committee of Barnwood House have recorded how much they esteemed him. Further testimony was forthcoming at a dinner given in his honour by medical men from all parts of the county of Gloucester. The speeches made on that occasion manifested the high regard in which he was held by his medical brethren, and their deep sense of the loss they would sustain when he left the county. We realise that Dr. Soutar's retirement must have been a sorrow to his patients, to whom he has always unsparingly devoted himself, and who regarded him not only as a physician, but as a friend; for his personal influence and his great gift of sympathy enabled him to give to them the help and support so largely needed.

The officers, nursing staff and the employés of the Hospital asked Dr. and Mrs. Soutar's acceptance of a piece of plate and of an address in which they expressed their sorrow at his resignation, the esteem and affection felt for him by all, together with the hope that both he and Mrs. Soutar might enjoy long life, health and happiness.

Those of us who had the opportunity of entrusting patients to Dr. Soutar's care at Barnwood House cannot but share in the widely-felt regret at his resignation. At the same time we trust that, having been relieved of his onerous duties, he will be able without detriment to his health to render to our Association, and to the medical profession generally, services which he is so admirably fitted to perform.

#### OBITUARY.

Dr. GEORGE WILLIAM MOULD.

By SIR GEORGE H. SAVAGE, M.D.

IN giving an obituary notice of Dr. George William Mould, I shall first include an outline of his personal history, contributed by his son; later, I shall give an appreciation of his work, and also a full reference to his address as President of the Association.

Born at Sudbury, Derbyshire, in 1835, he was the only son of his father's first wife. His father was a tenant-farmer and land agent; his mother, Miss Bakewell, belonged to a local family, also occupied on the land. His grandfather held the same land and the Rectory farm, and acted as land agent. He came from Sandilacre, Nottinghamshire, where his family had been yeoman owners of the same land for 300 years.

Dr. Mould was apprenticed to a firm of chemists at Derby at the age of 15, acting at the same time as dispenser to Dr. Fox; but then he left to be apprenticed to a surgeon, a Mr. Fletcher, at Uttoxeter, who many years after took charge of Loxley Hall, under Dr. Mould. While a student he won the Warneford Scholarship and Gold Medal at Queen's College, Birmingham, together with

other medals in medicine, surgery, and midwifery and allied subjects, including the Linnean Medal, also a prize for an essay proving the Divine origin of the world. General Anson, Commander-in-Chief in India, wanted him to go out on his staff, but his father would not consent. He was asked, also, to take temporary charge of a private asylum in the Midlands. This chance directed him to lunacy, and he was appointed Assistant Medical Officer at Prestwich. He then married Miss Spencer, a local lady, who died in childbirth two years after the marriage.

He was appointed Medical Superintendent of Cheadle in 1862, succeeding Dr. Maudsley, who held the superintendency of this hospital for only a short time. Later he became Lecturer on Mental Disease at Owens' College, Manchester. This appointment he held for many years, when the College became affiliated with Victoria University. At about this time, Holloway, of pill and ointment reputation, became a friend of his, as they were associated with the sport of coursing. He stayed with him at Cheadle, and Holloway formed so high an opinion of his abilities and was so struck with the establishment at Cheadle that he determined on building the Sanatorium at Virginia Water, and taking counsel with Dr. Mould wished him to become its first superintendent. This offer, however, he declined, though he accepted the compliment of being made a Life Governor. Among other things, he was offered a Lord Chancellor's Visitorship, but this, again, he looked upon as likely to interfere with his real interests in life, and, of all things, he seemed to dislike the restrictions that an official position would force upon him. He became President of the Medico-Psychological Association in 1880, and delivered an address, to which I shall refer later.

In 1864 he married Caroline, daughter of the Ven. Edward Woolnough, Archdeacon of Chester and rector of the neighbouring parish of Northenden, who predeceased him. By her he had two sons and three daughters. He subsequently married Edith, the daughter of Mr. Henry Sharp, manager of the Bolton iron works, who survives him.

During all his life he was devoted to field sports, and he used to say that his father took him out fox-hunting when he was only three years of age, and the father would set his children off and with bloodhounds drag-hunt them, and on occasion they might have to climb trees for safety. His fondness for sport and his determination to enjoy it is proved by the fact that when he was Assistant Medical Officer at Prestwich, with a salary of £80 a year, he nevertheless managed to keep a horse and ride to hounds. At Cheadle he was quite one of the hardest riders with the Cheshire and Meynell hounds. He also played polo—in fact, he claimed to have played the first game which was played in England, on the asylum ground. He also rode in a few steeplechases. He was especially delighted, however, in coursing, getting second in the Waterloo Cup on one occasion. In later life he took to fishing and shooting, which he followed up to the age of 70. In politics he gave unswerving support to the Conservative Party. In religion he held, without reservation, the beliefs of the Orthodox Party in the Church of England.

So much, then, for the son's narrative. By the death of Dr. Mould there has been removed one of the oldest of our members. For some years he had retired from all active work, and has not been seen at our meetings, so that the majority of members did not even know him by sight. Those of us seniors who knew him will always have a very warm and kindly recollection of him. Small in stature, with the most untiring energy, he planned and carried out great designs for the development of the treatment of the insane. His real life-work was connected with the Royal Asylum at Cheadle, near Manchester. He found it a small institution, and left it a model mental hospital. He had very strong views on developing the personal interests of patients and making the hospital a success. He enlarged its scope by adding country and seaside branches and convalescent homes.

As already stated, he was a man of iron constitution and most unusual powers of endurance. In the earlier days of the Association he was one of the leaders in visiting the institutions controlled by other doctors, and very pleasant were the reunions which then took place. Dr. Mould's hospitality was of the most gracious kind: welcome and good cheer made visitors feel happy and at home.

As already remarked, he was a keen sportsman, and for years coursing was his favourite pastime, and he was an excellent judge of both dogs and men.

He was too busy a man to write much for medical papers. The only production we have in the Journal by him is the address when he was President of the Association. Writing of any kind he abhorred, and many amusing accounts used to be given of the difficulties which arose from his ignoring the letters even of the authorities. If I wanted an answer myself, I used to enclose a directed post-card, with the information that this would be repeated until I did get an answer.

The time is coming when men like Mould, I fear, will not be available. The tendency is for the administration to be separated from the medical control, and once more there will be a return to lay control and more medical research. Of this I will not write more, but I recognise that such men as Mould have done enormously good work.

Dr. Mould gave his address as President of the Medico-Psychological Association in 1880. As might have been expected, it was a very practical one, and in many ways pointed to alterations in lunacy law, which have since been made or are still under consideration. He referred to an agitation, which was then taking place, against private asylums, and pointed out that there was no sufficient evidence that there was neglect of patients or selfish interests in the management which needed any drastic measures of reform. He referred to the development of single cottages in asylum grounds, and also to convalescent homes. And here one may say that although this has been established and recognised by the Board of Control for some years, there seems to be a tendency on their part just now to modify the permission. He pointed out the objection he had to certain lunacy forms, and protested against the alleged necessity for the two doctors who had to see the patient and sign the certificate being forced to see the patient separately, as he maintained that in many cases a full, complete and accurate knowledge of the symptoms of the patient and his condition was not to be derived by a single independent inspection. He made the suggestion that the Board of Control should not only arrange to visit asylums, but that it would be a good thing if the committees of the asylums could see them personally, and confer on any suggestions that they might make.

On the need for proper training of mental nurses, especially those to be provided for the nursing of mental patients away from asylums, he insisted very strongly. He urged, what was secured in 1890, some protection for the medical men who provided the certificates of lunacy. He also directed attention to pensions for doctors and nurses connected with the various institutions, and pointed out that the service in such institutions should be regarded as continuous, so that a doctor or a nurse moving from one county asylum to another should have the service at the two asylums as contributing to the pension. A thoroughly useful paper was given, which made quite clear the views derived by Dr. Mould from a very vast experience.

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#### AN APPRECIATION.

By Dr. D. NICOLSON, C.B.

*Lord Chancellor's Visitor.*

In 1862 Dr. Maudsley visited Prestwich Asylum and said to Dr. Mould, then the Assistant Superintendent, "You must come to Cheadle after me and you will either mar it or make it. Dr. Mould went, and he made it. It was the home and the centre of his activities for nearly half a century. Not only did he increase the accommodation of Cheadle itself fivefold up to a population of over 300 patients, but he was a pioneer in the establishment of villas, cottages, and outlying houses, where individual inmates or limited number of inmates were provided with home-like surroundings, where more freedom of movement and association with the outer world were encouraged, and where the sanction of visits by relations and friends was greatly appreciated. More important and larger branches were started in Staffordshire and North Wales and met with a success which was especially gratifying to Dr. Mould, who had ever in his mind the well-being of his many patients with their varied mental idiosyncrasies.

It was not my privilege to know Dr. Mould well until about the year 1896 when I visited Cheadle officially and had an opportunity of realising the important nature of the work he had done, and the wisdom which had guided him in catering for the comfort and happiness not only of his Chancery patients but of the inmates generally. After that, and more especially after his retirement from active work, I saw a good deal of him from time to time, and could not fail to appreciate his strong and attractive personality, his general force of character, his sanguine temperament and his sympathetic and unselfish disposition—characteristics which were knit together in happy union by a generously hospitable nature, and a keen and all-pervading sense of humour.

Dr. Mould's shortness of stature was counterbalanced by a development of brain which was proportionately large, and which provided him with a special intelligence and intuitive ability for diagnosis and treatment.

His wiry physique was well adapted for the good all-round sportsman that he was, and he never was in better form than when telling of his runs with the Cheshire or the Meynell Hounds, or recounting his adventures with his fishing-rod or on the moor. He was fond of coursing, and won steeplechases, and is believed to have played on Cheadle Asylum ground in the first game of polo in England. He was very successful with his pack of greyhounds and in breeding mountain ponies. I have only recently heard that he served as a volunteer officer in the days when we were expecting invasion by Napoleon III.

In lunacy matters Dr. Mould was a law unto himself and rather sketchy in his interpretation of legal formalities; but I am not aware that he came to grief or was other than successful in his independent schemes or methods. He had a pleasant memory of compliments paid to him by Lord Shaftesbury, who was a guest at his dinner as President of the Medico-Psychological Association in 1880; and he told me with a merry chuckle that when dining in London on one occasion with Sir James Crichton-Browne he met Mr. Phillips, one of the Legal Commissioners in Lunacy, who said to him: "I know you are a very good fellow, but you have given me more trouble than all the other superintendents put together."

Outside his professional work and his sporting proclivities, Mould was a *raconteur* whom it would be difficult to beat, and a keen Freemason and a good fellow. His stories were very largely original and often told against himself. Once when taking his University class round the asylum after his lecture—and he was an instructive lecturer and good speaker—they happened upon a patient, a gentleman of the philosopher type, who took the opportunity of orating for the benefit of the students, and concluded by saying: "Well, gentlemen, perhaps you don't know much yet, and they say a little knowledge is a dangerous thing, but since I came here I have found a little doctor who is a damned sight more dangerous." The "little doctor" was beloved by his students, but they enjoyed the piece of banter. Space limits me to one more story. Mould used to relate with some pride how he persuaded a jury to bring in a verdict of "accidental death" in a case where one of his patients had deliberately stood up facing a train and got run over. The coroner afterwards told him he ought to have been an advocate.

On his retirement, eleven years ago, he for some time found life and its concerns irksome and depressing, but he got over this stage and settled down in his easy chair, reading novels and light literature, and welcomed his friends gladly up to the good old age of 84 years, retaining his marvellous memory of his manifold experiences to the end, when he "passed peacefully from sleep into unconsciousness."

Dr. Mould was three times married. By his second wife he had two sons and three daughters. The sons, Gilbert and Philip, are doing extensive work in lunacy and diseases of the nervous system throughout the north and west of England. His third wife, who was Miss Edith Sharp, of Manchester, and who survives him, is a lady of much charm and sagacity, and did excellent work during the war as Commandant of the Red Cross Hospital at Colwyn Bay. She was the constant helpmeet of her husband and looked after him with untiring devotion.



## NOTICES BY THE REGISTRAR.

*Nursing Examinations.*

Preliminary Examination . . . . . Monday, May 5th, 1919.  
Final Examination . . . . . Monday, May 12th, 1919.

An Examination for Certificate in Psychological Medicine will be held in London first week in July.

Essays for Bronze Medal must reach Registrar not later than June 10th.

There will be an Examination for Gaskell Prize first week in July.

Particulars of above from Registrar, County Asylum, Hatton, Warwick.

## THE LIBRARY OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

MEMBERS are reminded that the Library of the Association at 11, Chandos Street, Cavendish Square, W., contains many books which are of great value for the purpose of reference. Recent publications are bought from time to time, and if any member desires the use of a book not in the Library, it can be obtained by means of the subscription which is paid to Messrs. Lewis's Lending Library. Application for any book should be made to Mr. Geo. Bethell, 11, Chandos Street, Cavendish Square, W.

R. H. STEEN,

*Secretary to Library Committee.*

## APPOINTMENTS.

Townsend, Arthur, M.D., Medical Superintendent, Barnwood House, Gloucester, *vice* Dr. Soutar, resigned.

Brown, R. Dods, M.D., F.R.C.P. Edin., Medical Superintendent, Royal Asylum, Aberdeen.

Kennedy, Hugh T. J., L.R.C.P. & S.I., Enniscorthy District Asylum, *vice* Dr. Drapes, resigned.

## NOTICE TO CONTRIBUTORS.

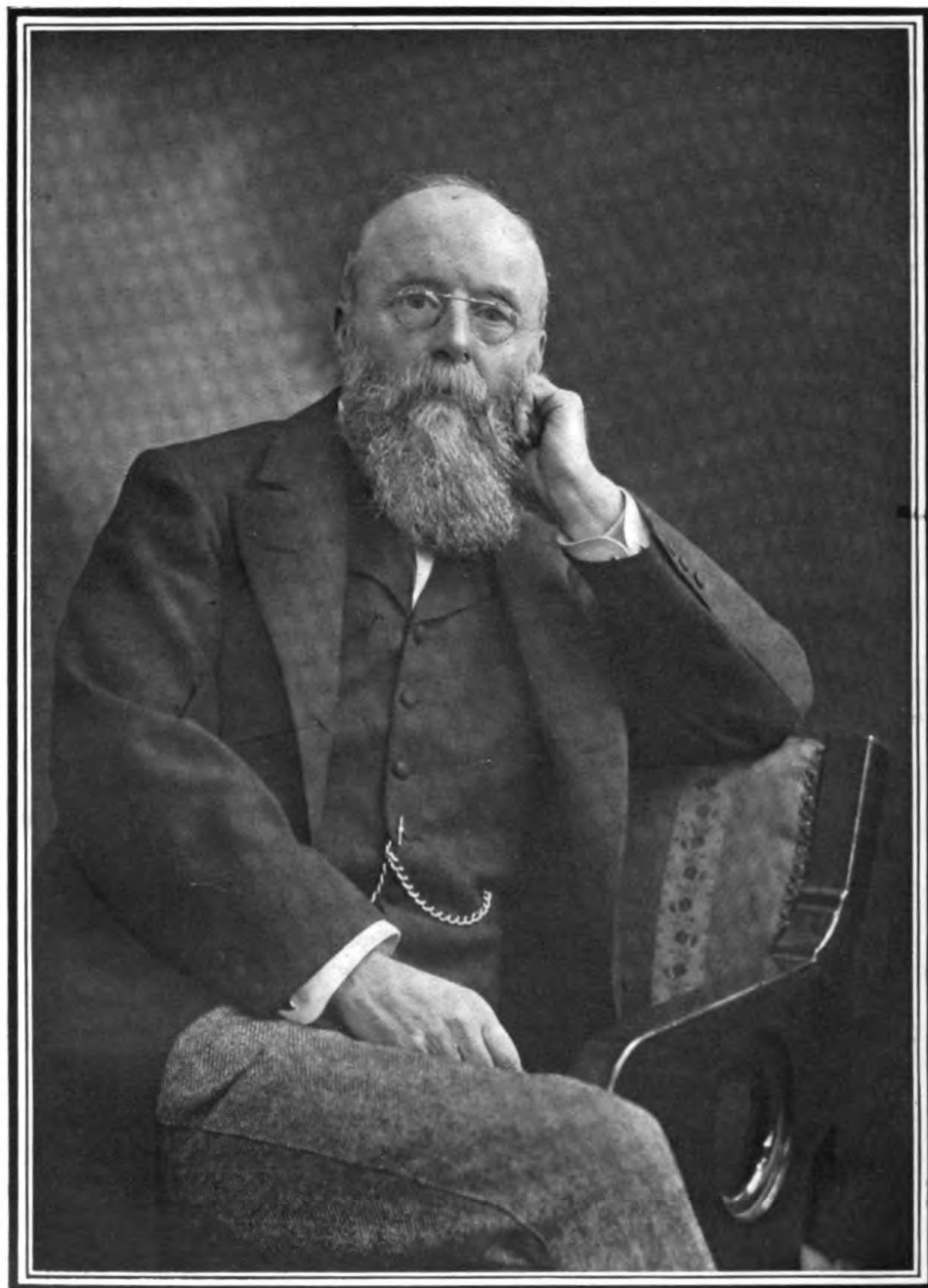
*N.B.*—The Editors will be glad to receive contributions of interest, clinical records, etc., from any members who can find time to write (whether these have been read at meetings or not) for publication in the Journal. They will also feel obliged if contributors will send in their papers at as early a date in each quarter as possible.

Writers are requested kindly to bear in mind that, according to LIX(a) of the Articles of Association, "all papers read at the Annual, General, or Divisional Meetings of the Association shall be the property of the Association, unless the author shall have previously obtained the written consent of the Editors to the contrary."

*Papers read at Association Meetings should, therefore, not be published in other Journals without such sanction having been previously granted.*

Dr. Drapes having resigned office as Medical Superintendent of the Enniscorthy Asylum, his address after May 20th prox. will be: Milleen, Dalkey, Co. Dublin, where all correspondence in future should be addressed.





JOSEPH WIGGLESWORTH, M.D., F.R.C.P. Lond.

Obiit May 16th, 1919. President, 1902-3.

*Adlard & Son & West Newman, Ltd.*

THE  
JOURNAL OF MENTAL SCIENCE  
[Published by Authority of the Medico-Psychological Association  
of Great Britain and Ireland.]

No. 270 [NEW SERIES  
No. 234.]

JULY, 1919.

VOL. LXV.

Part I.—Original Articles.

*The Present Position in Clinical Psychology.* Presidential Address  
by WILLIAM McDUGALL, Major, R.A.M.C.(Temp)., M.B.,  
F.R.S., at a meeting of the Section of Psychiatry of the Royal  
Society of Medicine held November 19th, 1918. [By kind  
permission of the writer and of the Royal Society of Medicine.]

IN choosing a subject for this address, I have felt at liberty to go  
outside the boundary of *psychiatry*, and I propose to put before you a  
slight sketch of the present position in *clinical psychology*. First, it is  
necessary to explain what I intend to denote by this term. It may be  
said that there is not and cannot be any branch or section of psychology  
that can properly be so called; for the clinician necessarily deals with  
his patient as an entire organism, and cannot, in considering his mental  
life, abstract from any one part or function of the mind to concentrate  
his attention upon another; his psychology therefore must be concrete  
and must deal with the mind as a whole. This is true, and it follows  
from this truth that, when our knowledge of the human mind shall  
have become an adequate and well-established science, that science  
must be the theoretic basis for all who are practically concerned with  
the working of the mind, whether they are chiefly and immediately  
concerned with the normal mind or with minds in disorder.

But, as I shall presently show, it is just because we have hitherto had  
no such psychology that there has been growing up of late years a  
specialised form of mental science which may conveniently be desig-  
nated *clinical psychology*. There can, I think, be little doubt that a  
century hence the present time will be held to be remarkable for the  
great advances made in our understanding of the mind, and it will be  
recognised with gratitude that clinicians have played a great and  
leading part in this achievement. My purpose is to attempt a rough

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10



sketch of the way in which this achievement of the clinical psychologists will appear to the historian of science in that future age.

In order to understand the rise of clinical psychology as a semi-independent body of thought, we must glance at the state of academic psychology in the later decades of last century. There is some foundation for the jibe that there were then as many psychologies as psychologists; yet there were certain doctrines which, especially in the psychologies that claimed to be scientific rather than philosophical, dominated the scene.

The chief of these were: (1) *Atomism*, or *sensationism*; (2) *associationism*; (3) *hedonism*.

*Sensationism*, the theory that all mental states, broadly spoken of as *presentations* or *ideas*, are aggregates formed by the compounding or clustering together of smaller fragments of conscious stuff, the elementary sensations; one idea differing from another merely in the number and variety of the units of sensation combined in it (hence the name *mind-dust theory*).

*Associationism*, the theory that all this compounding and clustering of units to form ideas, as well as all the succession and interplay of ideas, was ruled by the one great principle of *association*.

These two great principles were natural complements, and, therefore, were almost inevitably and everywhere combined. This combination was very widely accepted, owing not only to the seductive simplicity of the notion, but still more perhaps to the fact that it lent itself to combination with the increasing knowledge of the structure of the brain, to form a purely mechanical and materialistic theory of mental life. For the mental elements were regarded as being functions of the brain-elements or cells, as the sound of a plucked string is a function of the string; and the ideas or clusters of elements were likened to the chord heard when many strings are plucked or sounded together. Association was a function of the connections between brain-cells; and all the play of mental life was but a matter of the ringing up of brain-cells and groups of cells by the spreading of the nervous impulse from group to group, according to the simple principles of mechanical association.

British thinkers, Locke, Hartley, the Mills, Bain, and Herbert Spencer, to mention only a few of the most distinguished, were chiefly responsible for the immense success of these two principles.

To some thinkers these two principles alone seemed sufficient to account for all thought and all action; for *to will* was to have an idea of an action or movement, and these ideas of movement were, like all others, subject only to the great law of association. This was the theory of ideo-motor action, dearly beloved of so many of our French colleagues, and unduly emphasised by many of them. But others

could not overlook the fact that men commonly act, not merely because an idea of action comes into their minds, but because they have a purpose, seek some end, or strive to achieve some effect; and, looking round for some formula to define that end, they said—It is *pleasure*! In acting, in seeking, in striving, men, they said, are always moved by the desire of pleasure. There you have the third great principle of *hedonism*.

The psychologies which did not base themselves upon these principles were in the main highly metaphysical, and not such as to engage the attention of physicians struggling with the problems of mental and nervous disorder. And so we find that these physicians adopted, almost without exception, the mechanistic psychology founded on atomism, association, and hedonism.

This psychology, however, was wholly inadequate to the needs of psychiatrists. Its specious principles afforded little or no help when brought to the practical test of use in the interpretation of mental disorder.

And the natural consequence of its acceptance by psychiatrists was that those among them who were moved to research devoted themselves almost wholly to the attempt to discover the material basis, the neuropathology, of mental disease, this tendency being strongest where the mechanistic psychology was best established—namely, in England and Scotland; while the practical physician used the psychology of common sense and common speech, supplemented by his own intuition and large experience of men—a condition of affairs illustrated by the majority of the older text-books still in use.

I will further illustrate the position by reference to the writings of three leaders of psychological medicine, in Germany, France, and England respectively.

Prof. Ziehen, whose works have enjoyed a wide circulation, represents the pure principles of mechanistic materialistic psychology based on the three principles mentioned above. His psychology claims to be a physiological psychology; in reality it is a speculative and highly dubious brain-physiology which for psychiatry is utterly sterile. Psychology of this sort seemed at one time to have achieved a triumph in its interpretation of the varieties of aphasia, but it is, I think, now generally recognised that this triumph was illusory, and that in the main it obscured and distorted the facts.

Prof. Pierre Janet may justly claim to be the father or founder of clinical psychology. Starting with the principles of the mechanistic psychology, and, like other French writers, attaching great importance to the notion of ideo-motor action, he greatly developed the conception of *mental dissociation*. But valuable as was this contribution, his work would have remained on the purely descriptive plane had he not

broken away from the mechanistic psychology by introducing a new conception quite incompatible with it—namely, he conceived the mind to be pervaded by a synthetic energy, variable in quantity, whose function is to hold together in one stream of consciousness the various sensory elements, and in defect of which dissociation of consciousness into partial streams occurs.

In this country, the transition from old to new doctrine which I am attempting to sketch is illustrated in the most striking way by the work of Dr. C. Mercier. This brilliant writer, after having expounded the mechanistic psychology with great force and confidence, has made the discovery that in presence of all problems of action it leaves us utterly helpless. Thereupon, instead of undertaking a radical revision of his psychology, he announces our need of a new and distinct science—namely, a science of conduct (which he proposes to call *praxiology*)—and writes a new volume to lay the foundations of this much-needed science. No happier illustration of the inadequacy and sterility of the mechanistic psychology could be found. In taking this course Dr. Mercier was unconsciously following the example of John Stuart Mill, who began by adopting and expounding the purely mechanistic psychology of his father; and then, discovering, like Dr. Mercier, that it threw no light on problems of conduct and of character, sketched out a new science to fill this gap, proposing to call it *ethology*. Thus does history repeat itself even in the realm of science.

These three thinkers I have cited fairly represent the many others who have vainly striven to bring the mechanistic psychology to the aid of medicine. No wonder, then, that others have thrown aside all academic psychology in approaching the problems of the disordered mind; and it is perhaps well that they have done so; for their relative freedom from the paralysing shackles of the mechanistic psychology has enabled them to make progress; but their repudiation of all academic psychology has inevitably resulted in those peculiarities of the clinical psychology of our time which mark it off from the main stream of psychological tradition and development.

This method of approach and these consequences are best illustrated by the work of Prof. S. Freud, who, whatever verdict may ultimately be passed on his psycho-therapeutic methods, will certainly rank as one who has given a great impulse to psychological inquiry. Freud's psychological work may be said, from the logical point of view, to have begun from the wrong end. Without any preliminary attempt to consider first principles of mental life, to analyse consciousness, or even to define the terms which he uses, this daring and original inquirer has wrestled at first hand with the problems of conduct, and especially with the problems of disordered conduct as presented to him by his patients in all their concreteness and complexity. Thus approaching, he has

been deeply impressed by the great fact that much of human conduct, both normal and abnormal, proceeds not from consciously reasoned motives nor from any chain of association of clear ideas, but from a great impelling force that works within us, expressing itself only very obscurely in consciousness as vague feeling and uneasiness. This he has recognised as the sexual impulse; and, having been deeply impressed by the far-reaching effects of this upon conduct, and by the obscure and devious modes of its operation, he has gone on to bring under the same heading whatever other forces of a similar nature he has seemed to detect as co-operating with and subserving it, or which the vagueness of common speech seems in any way to connect with it. In this way, in his reaction from the mechanistic psychology, he has brought to light two great allied facts: (1) The impulsive, demoniac, illogical nature of much of human thought and conduct; (2) the very partial and inadequate way in which consciousness or self-consciousness reflects or represents the workings of this impulsive force. Freud's insistence on these two facts is his fundamental contribution to psychology; and it is the recognition and emphasis of them, thanks largely to his labours, that is the key-note of clinical psychology at the present time.

Freud's development of these two truths has been marred by several errors: First, his attribution to the sexual impulse of much of conduct that is not properly so attributable, and his consequent exaggeration of the rôle of sex; secondly, he has not wholly freed himself from the errors of the mechanistic psychology, in spite of his detachment from tradition, so natural are these errors to the scientific mind; two especially he has retained—(a) instead of repudiating the mechanistic determinism, he claims that he has for the first time established this principle in psychology; (b) instead of repudiating *hedonism*, he has made it his own and attempted to combine it with his recognition of the impulsive nature of conduct, as what he calls the *pleasure principle*, in a very confusing way that largely vitiates his thinking. A third great blemish is, that, having repudiated the traditional terminology of psychology and having neglected to define his own terms by careful analysis, his terminology is often obscure and misleading, and, as a further consequence, the large unanalysed conceptions with which he operates tend to become anthropomorphic agencies—the unconscious, the censor, the foreconscious, etc.

But in spite of these large blemishes and beyond the two fundamental principles we may, I think, see in his work permanent contributions to psychology which are of especial value to clinical psychology and are playing a great part in its development. Notably (1) the conception of active continued repression of distressing memories—a conception distinct from and much more fertile than the dissociation of



Janet; (2) the conception of conflict in the mind going on below the threshold of consciousness and capable of giving rise to disorder of thought and conduct; (3) the symbolical significance of some dreams and of some forms of waking thought and conduct, and the value of these as indicators of conflict and repression; (4) the conception of the "affect" as a quantity of energy that attaches to ideas, and gives them their impulsive force in the determination of thought and conduct.

Let us now glance at the way in which others have contributed to the further development of these lines of thought. I refer first to Adler, who, working by methods similar to Freud's, has diverged widely from him. His chief contribution has been to secure recognition by clinical psychology of two great impulses which seem to have escaped the notice of Freud. He has recognised the great part in human life of an impulse of self-assertion, and of one of only less importance, an impulse of self-abasement or submission; and, applying to these what may perhaps without impropriety be called the Freudian method in psychology, he has assigned them an immense *rôle*, and seeks to show that their distorted working is the source of all the neuroses, just as Freud finds that source in the sex-impulse. And, though he has without doubt exaggerated their *rôle* in the neuroses, we must forgive this natural exaggeration in gratefully recognising that he has secured recognition by clinical psychology of these two important impulses.

An English clinician has in a similar way secured recognition for another great impulse. Mr. W. Trotter has discovered the gregarious impulse, and, in a brilliant and persuasive little book, has treated it by the *Freudian method*, that is to say, postulating this impulse, without first stopping to inquire—What is its nature? What are the limits and scope of its action? But, sweeping into its province whatever human activities are social or in any way dependent upon or related to the social groupings of mankind, he has made it appear as the mainspring of well-nigh all human activity, normal and pathological.

An American clinician has performed a similar service in regard to yet another fundamental impulse of the human mind. Dr. Boris Sidis has, by applying the Freudian method, sought to show that *fear* is the source of all the psychoneuroses, all those troubles of thought and conduct which Freud attributes to the sex impulse, and Adler to the self-assertive tendency and its opposite. And though, like them, he must be judged to have overdone his part and proved too much, he yet may claim the credit of having given to *fear* a secure place in clinical psychology. But this place has been overwhelmingly established by the observations of a large number of physicians upon the psychoneuroses of war; for they have learnt that many, if not all, of the modes of neurosis may be generated by the terrifying experiences of the battlefield—that is by fear, or, as they commonly prefer to call it, by the

*instinct of self-preservation.* Thus fear takes its place alongside sex, self-assertion, and the gregarious impulse, as one of the great impelling forces of thought and conduct which work independently of the promptings of pleasure and override the principles of mechanical association.

We may, I think, assume that clinical psychology has not yet come to an end of its advance along this line, and may confidently expect that there remain other fundamental impulses of like nature to be discovered by it playing their parts in the genesis of mental and nervous disorders.

Now, it is of the essence of these great fundamental impulses, thus revealed as the underlying motive powers of so much of thought and action, both normal and abnormal, that they are purposive or teleological, and are not to be deterred by pain, nor turned aside from their biological ends by pleasure. They override and dominate for their own purposes all the mechanisms of association and the hedonistic influences. Therefore their recognition in clinical psychology necessarily leads to a complete break with the mechanistic psychology. Freud's own teachings show clearly the purposive character of much in human conduct that had been regarded as merely the fortuitous outcome of mechanical haphazard association; that, in fact, is rightly claimed by his disciples as one of his greatest achievements. Thus he has himself undermined both the mechanistic determinism and the hedonism which he professes to maintain. And although clinical psychologists commonly use the phrase "mental mechanisms," this is only for lack of a better mode of expression; and some of them have grasped the radical transformation of psychology that must result from the recognition of the great rôle of these primary impulses—a transformation from the deterministic mechanical psychology to a teleological and indeterministic psychology, a radical transformation, because, in spite of the ingenuity of German metaphysicians, mechanical process and purposive action remain utterly and fundamentally different. Most notable among these is Dr. C. J. Jung, who in his *Analytical Psychology* has forcibly shown the practical clinical importance of this revolution, insisting that so long as we regard the symptoms of our nervous patients as wholly and mechanically determined by the past, we miss their true significance and render our psycho-therapy relatively sterile; he insists that we have constantly to bear in mind in all our procedures the fact that conduct is determined by ideals of the future that we strive towards as well as by the events of the past.

Jung also has made a further great step of a more speculative kind. Repudiating the excessive sexualism of Freud and insisting upon the importance of the food-seeking impulse, especially in childhood, he regards all the primary impulses as differentiations of one fundamental

energy, the life-force which sustains all our strivings, both conscious and unconscious, thus approaching, but from a very different direction, the conception of the *élan vital* which the greatest of contemporary thinkers, Prof. Bergson, has so eloquently expounded.

Turn now for a moment to that other distinctive feature of clinical psychology—the increasing recognition of the part played in conduct and mental life by processes that remain hidden from consciousness. It is difficult to make any general statements about this, because the greatest obscurity and confusion still reign. The facts have not been brought to light by clinical psychologists alone. Others have been impressed by their importance and have prepared the way—Schopenhauer and Hartmann, and F. W. H. Myers notably.

Janet, with his conception of dissociated sensations and ideas, has attempted to give greater precision to the conception of unconscious mental process; and others who, like Janet, have made large use of hypnosis, have brought forward as justifying the conception all the striking facts of post-hypnotic suggestion. Morton Prince especially, following in the line of Janet, has striven to introduce some clarity into the vagueness which enshrouds this region, by his demonstrations of co-conscious personalities and co-conscious ideas; and to my mind he seems to have made out his case for the truth of these conceptions in certain abnormal cases. But his conception does not cover the whole ground; it does not cover the unconscious or subconscious operations of normal life; and on these Freud has rightly insisted.

The reality, the richness, and the importance of these subconscious operations of the mind have been brought home to many of us with a new force by our experience of the functional disorders of warfare; for no one working among these cases can have failed to come across many instances in which the symptoms, both bodily and mental—amnesias, war-dreams, phobias, anxiety states, paralyses, contractures, epileptiform seizures, headaches, tics—have been undeniably traceable to emotional conflicts and repressed tendencies and ideas, which have operated wholly or partly beneath or without the clear consciousness of the patient.

But Freud and most of his disciples have followed in the line of the “unconscious” of Hartmann, of Myers’ “subliminal self,” and the “unconscious mind” of other authors—that is to say they have tended to confuse together in one unanalysed mass whatever contents and operations of the mind are not clearly conscious at each moment, and to make of this an anthropomorphic entity, a demon, a god in the machine, whose nature and powers remain entirely unlimited and incomprehensible. And Jung and his followers seem to me to fall in some degree into the same error. I say “error” because this way of treating of “the unconscious” seems to me unscientific; it tends

towards a vaguely mystical attitude which, however much in place in religious or metaphysical thinking, does not directly promote, but rather checks, further scientific inquiry into this problem.

I venture to think that this error is again the outcome of the contamination of clinical psychology with the fallacies of the mechanistic psychology which it professes to repudiate. For that psychology all mental life was a succession of clearly conscious ideas. It ignored the fact that these ideas are but the eddies and ripples on the surface of a stream, deep within which are the currents and forces of which those eddies and ripples afford only very imperfect indications. This truth is manifested all down the scale of animal life—the instinctive strivings of the animals generally bring them surely to their biological ends, without clear consciousness either of those ends, or of the means by which they are achieved, or of the objects which, by impressing their senses, guide their successive steps. And it is not otherwise with man: he also is borne on to his biological ends, for the most part but dimly conscious of those ends or of the mental forces and processes by which he achieves them.

Just because the mechanistic psychology had ignored these surging hidden streams of the life force, those who, revolting from its inadequacies, have found themselves confronted by evidence of their reality in man, have been startled by the revelation and have seemed to see beneath the only form of mind recognised by the older psychology another system of forces greater and more mysterious, which they have thus been led to regard as a distinct mind or entity—the unconscious, the subliminal, or subconscious self.

A third way in which clinical psychology is diverging widely from the mechanistic psychology is by its discovery of the mind's wealth of innate endowment. The mechanistic psychology inherited Locke's dogma that each mind starts out upon its course of individual experience as a *tabula rasa*—a blank sheet on which experience writes as chance determines.

The recognition of the primary or instinctive impulses, of which we have already spoken, carries clinical psychology a long way beyond this primitive and untenable position, showing the strong native bias of the mind to select and react upon impressions from the outer world, not only according to its individual past experience, but also and chiefly according to its inherited constitution. But among clinical psychologists there is a strong tendency to go further than this, to believe that much of the development of the individual mind is literally a recapitulation of the racial mind, a gradual unfolding at the touch of experience of modes of thinking and feeling and doing gradually acquired by many generations of ancestors. Only by this assumption can they explain the striking uniformity of symptoms which characterise certain mental



disorders, and the equally striking uniformity of thinking and feeling revealed by primitive myth and custom among the most diverse races of mankind.

This line of work in clinical psychology promises to contribute very importantly towards two of the greatest problems that confront the human intellect—one strictly biological, the other of more general and philosophical import.

The one is the problem of heredity. If that wealth of inherited forms of thought and feeling, towards which clinical psychology seems strongly to point at present, should be further substantiated, this result will decide the issue of the great controversy between those who deny and those who affirm the inheritance of acquired characters. For while it may, perhaps, be plausibly maintained that a few simple instinctive modes of feeling and action may have been impressed upon the race by natural selection alone, every demonstration of a greater richness of this inherited structure of the mind renders this explanation more hopelessly inadequate, and drives us back upon the Neo-Lamarckian view that the experience of each generation impresses itself enduringly upon the race.

The other great problem is that of the constitution of man, the age-long controversy between *materialism* and what in the widest sense may be called *spiritualism*. For so long as it is held, with the mechanistic psychology, that congenitally the mind is a *tabula rasa*, and the brain little more than a mass of indifferent nerve-tissue waiting to be moulded by impressions from the outer world, it may seem plausible to hold that all mental potentialities are somehow comprised in the material structure of the germ-plasm. But, with every addition to the demonstrable wealth of innate mental powers and tendencies, this hypothesis becomes more impossible and incredible. And it may safely be affirmed that, if anything like the wealth of innate endowment claimed now by some—*e.g.*, by Jung in his latest work—should become well established, then all the world would see that the materialistic hypothesis is outworn and outrun, and that each man is bound to his race and ancestry by links which, conceive them how we may, are certainly of such a nature that in principle they can never be apprehended by the senses, no matter how refined and indefinitely augmented by the ultramicroscope or by the utmost refinements of physical chemistry. I venture to insist upon this contribution of clinical psychologists towards the solution of these great problems, because few of them seem to have adequately realised the bearing of their work on these issues, which so far transcend in interest even the fascinating and important questions with which they are more directly concerned.

There are many other features of interest in the present position on

which I might dwell if time allowed. I have had time to touch only on these few which seem to me the most significant. I have said nothing of the burning questions of method in psycho-therapy, and to do so would perhaps be presumption on my part. But I would like to say one word in the nature of a warning criticism. We are repeatedly asked to accept satisfactory clinical results not only as evidence of the value of the therapeutic methods applied, but also as evidence of the truth of the psychological doctrines on which they claimed to be based. The whole history of medicine seems to me to show the danger and the fallacy of this claim. How many accepted therapeutic procedures have been shown to be worthless! How many others, whose value has been proved, have been founded upon, or held to prove the truth of, hypotheses which are for ever dead. And we are relieved from any compulsion to accept such evidence when we notice that the exponents of different methods, based upon different psychological doctrines, claim equally brilliant therapeutic results in the same class of cases; and how even the same clinical worker continues to achieve equally brilliant therapeutic results before and after a radical change of doctrine and procedure. I insist on this as a warning against dogmatism, as an appeal for mutual tolerance and the open mind in this great field where we all wander, groping more or less blindly, among the deepest mysteries of Nature.

I have tried to hint that clinical psychology, now launched upon a great career, is in the position of a brilliant and wayward child, which, throwing aside the traditional wisdom of its parent as of no account, sets forth to acquire a new wisdom *ab initio*, and which, though making great strides, is hampered through retaining all unawares some of the prejudices and errors that it believes to have put off. And this brilliant child, as it advances, will inevitably find that there was truth as well as error in that parental wisdom. For the mechanistic psychology was not the whole or even the better part of psychology: it was the work of a sect, a series of persuasive and brilliant writers, who evolved it by deduction from principles set up by physical science, rather than by the patient and detailed study of human and animal life; and it enjoyed a great vogue because it harmonised with the materialistic tendencies of the great age of physical discovery.

But we are now in the age of biological discovery, and since Darwin initiated this new age there has been growing up a biological and inductive psychology, a science not springing full blown, like the psychology of James Mill, or of Herbert Spencer, from the reasonings of one powerful mind, but a science, based like other sciences, on a vast mass of minute and careful observation, a slowly growing product of the co-operation of a multitude of workers.

This science is showing the same main tendencies, the same trends,

as clinical psychology. And it is a bigger thing than clinical psychology because it is based upon a wider field of observation and induction; it is greater as the whole is greater than the part. Clinical psychology cannot afford to ignore this greater stream and to remain in splendid isolation. It is to be hoped that it will renounce the effort to do so, that the brilliant child will return to the parental fold, bringing rich gifts, but gaining in return a greater breadth of view, a greater sanity and balance, a more precise terminology, a greater clarity of thought, and with these, a greater power of dealing effectively with those most distressing of the disorders that afflict mankind—the nervous and mental diseases.

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*Mental Wards with the British Expeditionary Force: A Review of Ten Months' Experience.* By W. D. CHAMBERS, M.A., M.D., Senior Assistant Physician, Crichton Royal, Dumfries (late temp. Capt. R.A.M.C.).

DURING the period from March 1st, 1918, to January 11th, 1919, the writer held the appointment of Mental Specialist to Boulogne Base, and was in charge of the mental wards for that area. These were located at No. 8 Stationary Hospital at Wimereux, and received all the mental cases developing in or brought to the Boulogne and Calais areas. In addition a number of cases were sent for report from the local standing medical board, and many cases were seen at other hospitals.

*Staff.*—At the time of my appointment the staff consisted of myself, two nursing sisters by day and one by night, a ward-master, twelve nursing orderlies, and one general duty orderly. The nursing orderlies worked eight-hour shifts, one shift relieving the other for meals, and taking night duty in rotation. All twelve had had previous mental experience, but in March, 1918, seven of them, being of category A, were removed and replaced by men of low category and having no experience. As there were frequently sixty or seventy acute patients in the wards this made their management difficult at times.

*Accommodation.*—At first this consisted of two huts at right angles, one containing forty beds, the other twelve beds and a day room, which served as overflow dormitory. There were four cubicles, only one of which had a door, two baths, three w.c. seats, and the usual offices. The other two sides of the square were formed by a corrugated iron fence, seven feet high, enclosing an airing court. All windows to the exterior were not only heavily barred, but covered with heavy iron mesh, immovably fixed and impossible to clean. The dayroom and cubicles were lit only by skylights.

Theoretically the accommodation was for fifty-six, but on my arrival I found ninety-two patients. The excess slept on mattresses on the floor. Fortunately a new hut containing forty-four beds opening from the day room was ready for use by May, 1918. The more oppressive of the bars and iron-mesh window-guards were removed, making the wards lighter and more airy, and towards the end of the year windows were provided in the day rooms, greatly diminishing the prison-like aspect of the place.

After urgent application a space of 35 by 40 square yards on the seaward side was obtained for exercise. It was surrounded by a forbidding fence of barbed wire, but allowed room for more free movements and some games, and afforded an unsurpassable view of the Channel and its traffic, and on a clear day of the cliffs of "Blighty." There was no verandah, but the bed-patients were taken out whenever possible. Their number varied from six to forty, but averaged twenty.

*Admissions.*—During the 10½ months under review there were 893 admissions, in addition to the 92 patients I found in the ward. This number included, besides men from Britain and all the Dominions, 12 Americans, 14 Portuguese, 2 French, 12 West Indian Negroes, 3 Indians, 3 Russians, 4 Poles, 1 Serbian, and 16 Germans. No officers were admitted. The admission-rate was always lower during active fighting, but this diminution was more apparent than real, and was largely due to mental cases being detained in other units when the trains were busy with wounded. The rate tended to be higher before a battle, as a result of units clearing out inefficient and hospitals near the line freeing beds. The additional stress and strain of a battle undoubtedly precipitates the symptoms of the psycho-neuroses in those already sickening, but I was unable to detect any notable increase in the incidence of insanity at such times. It appeared that a larger number of defectives broke down during heavy fighting, but my numbers were not conclusive. Cases from any part of the Front may be sent to any Base, and only the statistics for the whole battle-line could be of value in this connection.

*General Management.*—Another hospital at the base was appointed to take all cases of neurosis and psychoneurosis, and it was intended that only "mental" patients should be sent to my wards. A large number, however, of patients of the former classes were sent in. Some of them were greatly upset to find themselves in a mental ward, the fear of insanity being ever close to the psychoneurotic, but after I got a second ward I was as a rule able to keep them away from the worst cases and save them this anxiety.

All cases found to be suffering from a psycho-neurosis or from mental disease or deficiency were transferred to the United Kingdom. The doors of the convalescent ward were open all day. Parole was freely given and was only abused on one occasion—Armistice night. I was



fortunate in only having one escape, a syphilophobic psychasthenic, not on parole, who spent a night in the local venereal hospital and returned voluntarily. He had gained a knowledge of the symptoms of the dreaded disease which did him good. There were no suicides.

On the whole I found the soldiers extraordinarily good patients, and incredibly more amenable than similar civilian patients. The Army and its methods make their mark on a man soon. On two occasions when the wards were crowded and the weather bad, a few malcontents threatened to attack the orderlies and break out—there was always a considerable proportion of prisoners uneasy about their fate—but both threats fizzled out. Care was taken to avoid oppressive “militarism,” especially in dealing with neurotics, but no man was permitted a degree of slackness which would diminish his self-respect.

Air-raids were rather a problem. We were situated unfortunately on a convenient landmark—the coast from Gris-Nez to Boulogne—and the enemy aircraft, though they seldom dropped bombs very near, frequently passed overhead, meeting there the local barrage. All electric light was cut off on the merest hint of a raid, and we were dependent for light in the observation ward on three hurricane lamps turned very low. The first considerable concussion put these out, leaving a ward full of unreliable patients of various tendencies perilously free scope for their activities. Fortunately no accidents happened. Defectives and hysterical cases and the negroes were most alarmed on these occasions and needed encouragement. Maniacs and general paretics were the envy of all. Cases of depression and confusion, stuporose and delusional cases were unaffected as a rule. I used hypnotics rather freely on fine nights when a raid might be expected.

*Prisoners.*—Of the admissions, 125 were prisoners, either convicted or waiting disposal, including 22 cases of self-inflicted wounds. In most cases the offences were purely military in nature. Charges of desertion and absence without leave were, as might be supposed, particularly common. Cases of theft, insubordination, and assault also occurred, mostly in defective and paranoid cases. I was required to examine one murderer, in whom I failed to find any signs of mental disease or deficiency.

In the Army a very slight variation from the normal in conduct quickly attracts attention. In many cases the earliest attention takes the form of committal to the guard-room, but the occasional individual unfairness of this procedure is more than counterbalanced by the advantages of having the incipient psychotic put under treatment at once. I had never any difficulty in protecting a man from the consequences of an offence committed while he was not responsible for his actions.

Of the cases of desertion and absence without leave—the distinction

is delicate but definite—the majority were the subjects of simple hysterical fugues. All degrees of dissociation were found. Some after a comparatively prolonged absence were clean and tidy, apparently well fed, and in no way likely to attract attention. Others were dirty and exhausted, and had obviously been less able to look after themselves. Some on admission were completely dissociated and disorientated; others, except for slight retardation, behaved and conversed naturally, and said they had, for a time, forgotten their name and unit and had been wandering about. Others in an intermediate condition were still unaware of their identity, showed some confusion, had no conscious insight, yet accepted a hospital bed without surprise.

As was natural, considering the psychological mechanisms at work, the majority of these cases made for Boulogne, and were arrested in or near that town. Some, however, wandered aimlessly about the country. The French peasants fed them, and they got stray meals in British camps and billets. The fact that so many profoundly dissociated cases managed to elude the numerous and inquisitive military police as long as they did is astonishing, and argues a very considerable degree of unconscious alertness and cunning. In many of these fugues the amnesia was absolute only for the act of leaving the unit, and a gradually diminishing haziness of recollection covered the remainder of the period. In other cases the amnesia was clear cut at both ends. In some cases the offence occurred while the patient was on leave in England—usually after he had left home for the return journey. Few of these cases were of longer duration than a few days, and they differed in no way from those which took place in France.

I had had little previous experience with this type of case, and found that some of them gave me considerable difficulty, particularly those of longer duration with few symptoms on admission. In some of them the restoration of the amnesic period led to an unfeigned emotional outburst. In some I was able to obtain a history of definite physical or psychical shock. In some the fugue was apparently motiveless and unlikely to be of service. One case, presenting practically no other symptoms, had frequent terrifying battle dreams. In almost all analytic conversation revealed the activity of a complex. A common symptom was a fixed local feeling of painful pressure or tightness in the head, which varied with the degree and extent of the amnesia. Many also showed listlessness or apathy, which with the headache vanished when the memory became complete.

Panic flights by defectives accounted for most of the remaining absentees. Absences in this category tended to be shorter and there was no real amnesia. The diagnosis was easy.

The estimation of responsibility for crime in the case of men who plead amnesia is highly important, and has not received very much

attention. Even admitting the amnesia to be genuine, in the absence of other psychoneurotic symptoms can responsibility be denied? Amnesia is a result of dissociation and repression which are by no means pathological processes, but are in minor degrees normal and natural to all. Wishes, tendencies or thoughts which are unpalatable or unacceptable or antisocial are being harboured by most of us, and are constantly being repressed and kept from consciousness by the psychic censor, and their continued repression and powerlessness to affect our consciousness or our conduct is due to the watchfulness and strength of this censor. The psycho-pathological explanation of the crimes we are discussing is that a wholly or partly repressed complex eludes or overcomes the psychic censor, and becomes sufficiently powerful temporarily to suppress consciousness and to gain control of the bodily activities. The mechanism is the same whether the desired end be trifling and unimportant, or antisocial and an infringement of law and custom. The difference is solely one of degree. The man who abstractedly burns or loses his tailor's bill, and he who unconsciously leaves his regiment on the eve of an attack are actuated by the same driving force working in the same way. The conduct is favourable to the individual but unfavourable to the herd. In some people the instinctive individualistic wishes are very completely suppressed, and are never able to influence conduct. In some the suppression is less thorough, and activities incompatible with conscious control may be aroused and displace consciousness. In others the altruism demanded by herd instinct is feeble or non-existent, and a more or less consciously deliberate career of crime is chosen. Excepting certain outstanding cases, who are called moral defectives, and incarcerated in asylums instead of prisons, members of this third class are commonly regarded as being in all respects responsible for their actions. It would appear difficult to justify the universal exoneration of wrong-doers of the second class, whose psychic censorship is powerful enough to entail a temporary dissociation of consciousness during their anti-herd activities, but not to prevent those activities altogether. The force of example afforded by the condemnation and punishment of others will assist and reinforce the censorship that is inclined to waver. Those cases, however, who have offended against the herd, but who, as a result of prolonged and stubborn resistance to the tendencies of individualism, exhibit pathological symptoms of the conflict in the form of insomnia, anxiety, terrifying dreams, etc., appear to be entitled to exoneration and to removal if possible to an environment where the psychic control may be able to cope with the desires of the individual.

In three cases of absence I was satisfied that the offender was in all respects responsible for his actions.

Pte. H— was found near the docks in Boulogne, clean and tidy

and behaving naturally. He was without pay-book, identity disc, or papers, and a portion of the side pocket of his tunic on which a soldier commonly writes his name had been recently cut away. He complained of nothing, but stated he could give no information whatever about himself, or any part of his history. He had no physical signs of disease. During examination he seemed uneasy and on his guard. He had no headache, showed no confusion or retardation, and gave his answers quickly. In a long conversation it was possible to trap him in inconsistencies. His "amnesia" was unusually resistive, and the order in which he eventually "remembered" his particulars, etc., was unnatural. He had a bad record with his unit.

Pte. S—, also with a bad record and charges of desertion and prison-breaking both in England and France against him, was sent in complaining of "loss of memory and not knowing what he was doing." I found his amnesia capricious and variable, and quite unsupported by other symptoms or by a suggestive history. I was unable to hypnotise him. After prolonged observation I discharged him as fit to stand his trial.

Pte. P— had, among other charges, one of desertion to the United Kingdom for twelve months against him. On admission he feigned symptoms which he conceived to be psychotic; later he pretended to be a defective, and finally, after his medical board, he stated he had recovered. At no time did he show signs of mental or nervous disease. It was only after great hesitation I decided he fell outside the class of moral defectives and sent him for trial. From this man and from one or two others I gained some knowledge of the remarkable trade in pay-books, passes, leave-warrants and other evidences of identity carried on in soldiers' hostels and clubs.

Other offences were rare and as a rule unimportant. I shall allude to them elsewhere.

*Self-inflicted wounds.*—Of the 22 "self-inflicted" cases, 3 were definitely not suicidal in intent, 1 being deliberate to avoid duty, 1 the result of a drunken fight, and 1 following the attempt of a general paretic to kill rats with a Mills's bomb. The suicidal wounds comprised the following: 14 cut throats, 2 gunshot wounds, 1 bayonet wound, 1 precipitation from a train, and 1 man who threw himself under a lorry. None of these patients were responsible for their actions. The very small proportion of cases in which firearms were used is striking, and in my opinion results partly from the probability that when a soldier attempts suicide by shooting he is almost invariably successful, and so rarely gains a place in statistics. There is no doubt that in heavy fighting under adverse conditions, as at Passchendaele in November, 1917 numbers of men kill themselves. I agree with Stanford Read that mere mechanical difficulties in the use of the rifle are quite insufficient to explain why it is neglected. The choice of means is undoubtedly due to some unconscious psychic factor or factors, and I suggest a loathing of everything military as one possibility. It is also probable that the



daily contact of the razor with the throat in shaving exerts unconscious but cumulative suggestion on a mind torn asunder by hidden conflict, and revolting to the end from the rifle—that ever-present symbol of the hated environment. The two cases of gunshot wound which reached me were of the lower jaw. They illustrate incidentally the comparative absence of explosive effect resulting from close proximity of the muzzle of the modern rifle. In both cases the chin had been resting on the rifle, and there was a compound fracture communicating with the mouth. One man was an epileptic imbecile, four months in France and four days in the trenches, who ascribed a scolding from his sergeant-major as a cause for his act; the other was a “persecuted” paranoiac, æt. 38.

Of the cut-throat cases, 3 were due to hallucinations of alcoholic origin, but in one there was an obvious underlying psychosis, which was the cause of the alcoholism. In these cases the wounds were very severe. Six occurred in acute “persecuted” paranoiacs with hallucinations. It was remarkable how the mental condition of these cases improved in hospital. Two were cases of more or less pure depression, and the remaining three showed hysterical dissociation with dream delirium. In only one was there admitted conscious premeditation, and it is interesting to note that one of the dissociated cases was awarded the Military Medal for an act of gallantry performed a day or two before his suicidal attempt. In addition to these two men who attempted suicide by drowning in a state of dissociation were admitted, and two similar cases made resolute attempts by hanging and strangulation in the ward.

Almost all the suicidal cases showed amnesia for the event. This is the rule in civilian cases too, and is the natural consequence of the cleavage of the personality necessary before an act of self-destruction can be achieved. It would seem that such a reversal of the great primordial instinct of self-preservation could only result from some very profound disturbance of the mind. Yet that in certain cases this instinct can be apparently without difficulty neglected and set at naught is obvious. Defectives, and in some countries children, commit suicide on wholly inadequate and trifling grounds. The double suicides of lovers which occur almost weekly are remarkable instances of the—one might call it—levity with which this step may be taken. The common combination of murder and suicide is equally notable in its apparent absence of sufficient motive. The hara-kiri of Japan, the suttee of India, carry the strong approbation of the herd, and are less difficult to conceive, yet they are notable perversions. Epidemics of suicide such as have occurred at intervals in the world's history are in this class.

The psychological basis of the act is in all cases conflict, represented by psychic pain. Idiosyncrasy, the product of previous experiences, alone can explain the reactions of individuals to certain situations.

Suicide is reaction of an individual to a psychic conflict which may be partly conscious or wholly unconscious. This conflict may be comparatively superficial and recognisable as such, in the form of a feeling of inadequacy, of inefficiency, of failure. It may be ignored and concealed, but recognisable under a web of rationalisations. It may be buried and repressed and active only through distorted and fantastic hallucinations. It may be of intolerable pitch, yet so repressed that it betrays itself not at all. But whatever its relation to consciousness, this mental conflict may at any time attain sufficient momentum to over-ride the self-preservation instinct and provide its own final solution.

The following case illustrates the intensity of the conflict occupying the minds of some of the men who are driven to self-destruction, and the manner of its distortion in presentation to consciousness. In this case the content of the dream-delirium was remarkably vivid, and consisted of illusory distortions of the actual surroundings and not of hallucinations. The memory of it persisted very strongly during convalescence.

Pte. S—, æt. 38, two years' active service. Admitted in a state of terror and apprehension—restless and confused, not hallucinated, able to give his particulars. He had a long incised wound across his throat, not very deep. He soon became more dull and almost stuporose; apprehension diminished; had a fairly good night. Wept at intervals during the following day, but was obviously improving. Beyond feeding him and dressing his wound no notice was taken of him. On the third day he gave me the following account of himself. He said he had been one of a machine-gun detachment of four, guarding a road. (It was on the Somme during the German advance in April, 1918.) There were two other detachments near, all three under an officer. He illustrated the relative positions and the direction of the Germans, and he knew the names of his comrades. There were some shells passing over. Suddenly it dawned on him that his companions were Germans disguised in British uniform. One of them appeared to be a "nigger" as well. (He was hazy about this.) He realised it was his duty to inform his officer. He tried to steal away to do this, but was seized by the "Germans" and knocked down. He then became aware that the officer and men at the other posts were Germans also, and realised he had been captured. He was taken away and put in a bell-tent with a "black German" guard, and given straw to lie on. He heard voices without, saying the straw was to be set alight and the prisoner burnt alive. There was loud mocking laughter. Then he heard the ticking of a time-bomb, which was concealed in the straw. He searched frantically but fruitlessly, and finally to end his misery he took his razor from his pocket and cut his throat. Finding he did not die, he burst from the tent and tried to escape. He was pursued and dragged back among laughter and jeers. He "remembered" vividly the remarks and chaff to which he was subjected. He was hazy as to how he got back to the British lines.

No notes had come with him and for some days I believed he had

been in German hands and escaped. Many of our men had this experience in the open fighting of this period. I was able later, however, to ascertain the facts, which were as follows: He had had little rest or food for some days. He suddenly became very excited and uncontrollable while in a machine-gun post as he described. There was little shelling going on, and the Germans were not near. Two men took him to the aid-post, where he was put in a tent by himself and seemed to settle down. Presently he broke from the tent with his throat cut, and fled. He resisted capture and fought fiercely. For a few weeks he was depressed and dull, ate and slept poorly, stuck to his story without variation, but became unwilling to talk of it. At the time of his transfer to the United Kingdom he remembered his dream experience, but had little or no confidence in it, though he still had partial amnesia for the actual events.

*Classification of cases.*—In the classification of cases dealt with the nomenclature of mental disorders as laid down by the Army Council was necessarily followed in all official records. In view, however, of the extremely incomplete investigation possible in most of the cases, diagnosis was out of the question, and a temporary label for the patient's condition was all that was aimed at. Under the circumstances such records are almost valueless, and it is only with a view to indicating the types of mental disorder more prominently met with that I include the following table covering the 966 cases dealt with.

Feeble-mindedness . . . . .	153
Nervous debility . . . . .	29
Mental instability . . . . .	26
Moral imbecility . . . . .	4
Confusional insanity, including exhaustion psychosis . . . . .	136
Delusional insanity . . . . .	94
Mania . . . . .	82
Melancholia . . . . .	98
Dementia præcox . . . . .	101
General paralysis . . . . .	21
Alcoholic psychosis . . . . .	12
Stupor . . . . .	5
Constitutional psychasthenia . . . . .	7
Epileptic psychosis . . . . .	27
No appreciable mental disease . . . . .	22
Psychoneurosis . . . . .	134
Various . . . . .	15

As regards disposal, 763 were sent to D. Block, Netley; 127 were transferred to England as functional neurological cases; 39 (Americans, Portuguese, etc.) were transferred to other mental hospitals in France; 12 were evacuated as ordinary medical cases; 22 were discharged

direct; and there were 3 deaths. I will now proceed to discuss the different classes in more detail.

*Feeble-mindedness.*—Mental deficiency accounted for 153 of the cases. In many the degree of deficiency was amazingly high, and one wondered whether recruiting boards had any conception of the conditions of active service. Stigmata of degeneration were common, and many displayed infantile characters in greater or less degree. There was one striking case of physical and mental infantilism. About half of the defectives were sent to me for opinion by the classifying medical board at Boulogne, and belonged to the Labour Corps. Their average service in France was a few weeks, and in many cases they showed already early signs of psychosis, usually confusion or depression. These cases were particularly numerous in the early summer after the much-needed reinforcements had been hurried out from England. Numbers of these men were back in England within a fortnight of their original sailing. It is perhaps comforting to note that one U.S. soldier, a low-grade defective, was admitted within a week of his landing at Calais and within two months of his enlistment, with the history that his feeble-mindedness had been recognised before leaving America, but the procedure for leaving him behind worked so slowly that his unit was compelled to bring him.

The other type of defective, of a higher grade, had a better average length of service, and had made an effort towards adaptation. Many had two or three years' service in France with a labour unit, or even a regiment, though in the latter case seldom carrying out the duties of a fighting man. In all these cases psychotic symptoms gradually developed, confusion, stuporose states, and persecutory paranoiac ideas being the most common. It is unnecessary to dwell on the objections to placing such types in positions so full of possibilities of danger to themselves and others. Among the cases I had to deal with were one of attempted murder by shooting, one of indiscriminate shooting under the influence of hallucinations, and one of attempted suicide by shooting. All were definitely feeble-minded, with a tendency to the formation of delusions of reference and persecution. I have great sympathy with the units which are compelled to retain such types, as I have had personal experience of the difficulty in getting rid of them before the onset of psychotic symptoms. Even employment at a base or on the lines of communication is unsatisfactory and unsafe. The hours are long, conditions are hard, military discipline makes few allowances, and the "Gotha" and its kind provide thrills and shocks enough to unsettle at times the most stable. The defective, uprooted from the limited and comparatively simple environment he has known all his life, finds complete adaptation in his new state quite impossible, and his breakdown is but a question of time. On the other hand, the high wages some of



these men had been able to earn in civil life amazed me. A vocabulary limited to two hundred words with general knowledge to correspond does not prevent a Lancashire cotton spinner from earning his £3-£4 a week.

As might be expected many of the defectives had got into trouble and were admitted as prisoners. I do not think the authorities who send such types abroad realise how conduct which in a civilian would be unimportant may on active service constitute a serious technical misdemeanour, and lead to heavy punishment. The most common offence in this class was absence without leave or desertion—a purely military offence. The absences were as a rule short and often rather aimless. Some of the patients had already been sentenced on admission, and a few had even served part in a military prison. A Canadian soldier, Pte. R—, æt. 21, with nearly three years' service, was under sentence of death for desertion. He showed marked retardation, was backward and stupid, was undersized and poorly developed, and suffered from a striking hydrocephalus, the circumference of his head being  $24\frac{1}{2}$  ins. Some of the defectives attempted to assume psychoneurotic symptoms, but they were poorly executed, and when ignored soon dropped without remark. Pte. M—, æt. 18, with three months' service, was microcephalic, had never been to school, and could not read or write. He was a prisoner for desertion, pretended to the court to be completely amnesic for his past, and was sent down as “? mental.” In reply to all questions, he said, “I dont know,” “I forget,” etc. I satisfied myself that he was feigning, and was able in a short interview to convince him the game was up, after which he answered very willingly. Another defective, a barefaced and incorrigible rogue, had in civil life been in the habit of etherising himself with collodion-soaked cotton-wool placed in the nostrils.

*Nervous debility.*—In this class, which numbered twenty-nine, I included those who, not being feeble-minded in the usual meaning of the term, and without developing a psychosis, were unable to adapt themselves to new situations and environment. Their symptoms were constitutional timidity and diffidence, a tendency to hypochondriasis and introspection, and an indifferent hold on their mental balance. A few had had transient psychotic or psychoneurotic periods. They were all men who would in all probability have been able to cope with the problems of civilian life.

*Mental instability.*—I place next the class of those who, having no permanent psychosis, were pathologically unstable. They numbered twenty-six. In the main their condition was betrayed by increased and exaggerated reactions of various types, most frequently a short bout of excitement, and in many the differentiation from defectives was vague, and one or two suggested epileptic equivalents. By some these cases

are described as impulsive insanity. As a rule, however, the insane conduct, though sudden in onset, is of the nature of a reaction to a recognisable stimulus, marked mental enfeeblement being absent. Their symptoms were repeated, but transient, and I was rarely able to observe the patient during an attack. Such patients appear to escape certification in civil life. Two were old soldiers with twenty-four years' service and an alcoholic past, serving under N.C.O.'s of the new armies. One was a remarkable man, whose hereditary profession was having paving-stones, placed on his head, broken by blows with a sledge-hammer. His *nom de théâtre* was "Upper," and his sub-title "The Human Pincushion." He had apparently complete anæsthesia to heat and pain, but not to touch, cold, or deep pressure, below the elbows and on the face and neck. He stuck pins into these regions with indifference and showed many circular scars, the result of pressing lighted cigarettes into the skin. As side lines he broke bottles by hitting himself on the head with them. He was a clever tumbler, and I believe an expert at releasing himself when bound with ropes. He was a powerfully built man, looking more than his age, which was 45. He confessed that for many of his feats of endurance he fortified himself with liquor, and it was a demonstration in a canteen with beer bottles which led to his being sent to the mental ward. He stated that his anæsthesia had existed in its present condition as long as he could remember. Sensation elsewhere was normal. The superficial and deep reflexes were considerably increased, equally on both sides. There was no atrophic change pointing to acquired syringo-myelia, no spasticity or neuritis, and in view of the distribution the condition was probably hysterical. The notes which accompanied him stated that he was impulsive and violent-tempered, unduly susceptible to small quantities of alcohol, and liable to spells of furious excitement on little or no provocation. He was rational and lucid while under my observation, and complained of no disability. He showed neither physical nor mental signs of excessive alcoholism.

*Moral imbecility.*—There were four cases, in no way differing from those met with in civilian practice.

*Confusional insanity.*—Under this heading I placed 136 cases. They were of the most varied types, including all the degrees of intellectual obfuscation and retardation found in civilian practice. At one end they merged into delirium, at the other into stupor, and many cases similar to those placed in this group are classified with the "confusion" sub-group of the psychoneuroses.

The cases of pure confusion fell into two vaguely defined types, the toxic cases and those showing hysterical dissociation, but no definite differentiation can be made—in fact the psychological basis is probably identical. In the latter disorientation appeared to be more complete,

and the patient was part of, and living among, his hallucinatory surroundings. In the toxic cases the patient was, on the whole, less inaccessible, and his hallucinations were more superficial and affected his conduct less. In some of the hysterical cases imperception was so marked that the motions were passed into the bed, yet within a few hours reintegration took place, leaving no symptom but slight retardation and amnesia. Evidence of toxic origin, influenza, trench fever, etc., was obtained in about 20 *per cent.* of the cases, and in many of the others a septic condition of the alimentary tract was obvious. I had an opportunity of observing considerable numbers of severely wounded men suffering from delirium. All were gravely toxic, but some showed quite clearly a delirium of the hysterical type. Many of the cases were probably passing through a confused phase of manic depression or dementia præcox.

It appears that many very different conditions are commonly included under the heading of exhaustion psychosis or confusional insanity. As stated above, in about 20 *per cent.* of my cases a toxic element appeared to operate as a cause. But other patients displaying the same or similar symptoms brought a history which seemed to exclude toxæmia, and pointed very definitely to psychic trauma, prolonged or sudden. The influence of physical exhaustion as a cause of psychosis seems to have been greatly over-estimated. The pathological processes by which these varying causal factors produce the same syndrome are obscure. Kraepelin's opinion that nutritive changes occur with production of toxins, and neuronc poisoning does not throw much light on the question. The theory of Jelliffe and White seems of more value. They believe that the symptoms which a damaged neuron can produce during dissolution are limited in number and complexity, and depend, not on the nature of the destructive agent, but on the function of the neuron, and that minor variations are the result of individual make-up, not of differences in the agent. This theory, however, also predicates the existence of a toxin or metatoxin in all cases of marked confusion—a hypothesis which does not appear to be proved.

I will describe a case of dissociation illustrating a type of case which I returned under this group in which the causal factors were partly physical, partly psychic.

Pte. G—, æt. 21, service three and a half years—three years in France. Wounded once. Sound heredity and normal youth. No neurotic symptoms observed. Was noticed to be "run down" and sleepless for a few days only. Was sent to a forward rest-camp, where he received a wire informing him of his mother's death. Disappeared for four days, and turned up again dirty, unkempt, and starving. Was unable to speak, and was confused and restless. Sent to casualty clearing station he became agitated, apprehensive, terrified of the orderlies, etc., sleepless, refused food, habits dirty, and began to verbigerate "Back to my Army," and "100,000 black men in the north."

During this stage he was evidently suffering an acute and vivid hallucinosis. On admission was exhausted and weak, stared unseeing about, had marked imperception and disorientation, was not restless, allowed himself to be fed, etc. In answer to all questions he said "Back to my Army" again and again in a terrified and later in a pleading way, as if trying to make me understand. In a few days he lost all his apprehension, and began to sleep well and look well and content. Mentally, his condition was one of very profound imperception. If put to bed, and his eyes closed, he went to sleep. Pin-pricks, loud, sudden noises, the sound of his own name or nickname entirely failed to attract his attention, but if one stood in front of him he could hear and repeat single words, and later he learnt the meanings of a few, such as bed, smoke, eat, etc. When given food he was able to feed himself tidily, he could wash and dry himself, he went quickly and directly to the w.c. when necessary and made his arrangements perfectly when there, but he never learnt to adjust his clothes or his own bed, and would get into the first open bed he saw. He showed a curious degree of apraxia. He smoked cigarettes very efficiently and with enjoyment, but he would make earnest attempts to draw smoke from pencils, pocket-knives, etc. He could close a pocket-knife—taking infinite precautions—but could not open one. He learnt to strike a match if given one from a box, but he never learnt to open the box. He lit his cigarette well, inspected the burning end in the most typical "Tommy's" way, but was unable to lay down or blow out the match, and watched it burning down to his fingers with a growing look of horror. When it had burnt out he was able to place it in the ash tray. He appeared to enjoy cigarettes, but made no attempt to take one from his pocket, etc. He showed great delight when the canaries sang if he was looking at them, but he would sit for hours with his back to them, taking no notice whatever. His sense of possession was feeble. Anything he was given he tried to put under the nearest pillow. The predominance of his mental automatism was shown in his games with other patients. He could catch a slowly moving ball, but he invariably returned it with the hand he used to catch, and to the man who had thrown it to him. Nothing would induce him to depart from this. He slept unmoved through air-raids. Except in going to the w.c. I never saw him display any initiative. Taken out for a walk, he would walk straight on indefinitely. He experienced emotions of joy and sorrow, but very seldom and very superficially. His expression was one of happy idiocy, with an indescribable element of reproachful amazement. I was unable to hypnotise him or get in touch with him during sleep or by automatic writing. He was in the state described when transferred to England.

This case illustrates the combination of profound dissociation with absence of hallucinations, showing a condition distinct from the more typical "exhaustion psychosis" on one hand, and from the oneiric delirium with an hallucinatory or illusory system on the other. It is akin to the aprosexic form of confusion described by Rhoussy and Lhermite.

*Delusional insanity.*—I found a delusional state the most prominent



feature in ninety-four cases, excluding those who appeared, fairly conclusively, to be paranoid demented. Delusions of course occurred in all types of psychosis, but in a number of those returned as melancholia urgent delusions of a persecutory type, at times supported by and based on auditory hallucinations, were so marked as to render their classification doubtful. In some the condition was quite transient (notably in some of the defectives returned as such); the delusions were of a reasonable nature, not held with much conviction, and probably arose from a conscious or unconscious feeling of inferiority or inadequacy, and these cases responded well to rest and encouraging suggestion. The majority of the cases seemed to betray more or less distinctly the paranoiac disposition, and though only one-third had a well-fixed system of delusions, it appeared likely that many of the others would eventually develop the same. A type, showing fairly rapid development and the most intense conviction, frequently hallucinated, with delusions of persecution and reference and great suspicion, was strikingly evident. In most war-colouring, if present at all, was quite superficial; as a rule the sergeant-major or some officer formed the nodal point of the persecutory system. Homosexual ideas were distinctly more obvious than among civilians, and in this connection Stanford Read makes the interesting suggestion that "it would be suggestive to investigate the theory that the herding of men together in the Army where heterosexual intercourse is mostly excluded tends to arouse a latent homosexual trend against which the personality defends itself by 'projection.'" It appears to me, however, that the mechanism of projection, without necessarily a homosexual foundation, will satisfactorily explain this acute persecuted state, with ideas of suspicion and reference, and early support from hallucinations. In an army at war a soldier lives close to the essentials; the comforting minor rationalisations permitted in times of peace are denied him; the "mitigating circumstance" has little sway; if the other man is the better of the two, it is likely to be publicly proved beyond argument and with cruel directness. Intellectual talent is at a discount, and physical powers are predominant, and it is remarkable that the average man bears disparagement of the latter with much less equanimity than of the former. Projection then comes to the aid of the discomfited, and protects his peace of mind at the expense of his reason.

Almost all observers of the war have noted an unusually high proportion of such cases, and it is interesting that a similar psychosis was reported as common in the Russo-Japanese war. The patient in some cases reacts to his painful ideas by over-indulgence in alcohol. Similar mental states in civilians are almost invariably associated with alcoholic excess, and in these authorities differ in assigning the relative importance of cause and effect.

One or two interesting cases at an early stage passed through my hands.

Pte. P—, æt. 24, four years' service. No history of neurotic symptoms. Wounded once, sent down suffering from an (admittedly) self-inflicted wound, not as a mental case. Displayed the most intense and unfounded pessimism and distrust, without actual construction of delusions. No hallucinations or confusion. Irritable, unruly, difficult to control, reasonably polite to me only with an effort, insolent and objectionable to sisters, etc. Threatened suicide, though had numerous facilities. Took ungraciously and without thanks all privileges and attentions. No complaint of disability. Displayed no motion during air-raids.

Pte. H—, æt. 38, three years' service. Two self-inflicted wounds (denied, but certain). Symptoms as above.

Were these merely cases of the "fed-upness" of the average soldier carried to an extreme, or were they early stages of a progressive delusional nature? They suggested the *délire chronique* of Magnan. In favour of the latter theory was the unaltered scowl with which they greeted the first stage of their journey to England.

*Dementia præcox*.—One hundred and one cases presented symptoms which appeared to point to one or other of the types of schizophrenia. Their differentiation from hysterical and exhaustion cases was very difficult on a short period of observation. The resemblance was particularly close in cases showing mild stupor, with general retardation, motor and ideational inertia, emotional apathy, *flexibilitas cerea*, agreeable hallucinations, etc., combined with good orientation and grasp of the surroundings. Some such cases cleared up apparently completely in a few days in a way I have not seen precocious demented do. Most of the deluded types had made use of scenes and material of war for their delusions; for example, an army signaller said he received messages in Morse code from enemy aircraft on his teeth, and that he sent them false information in the same way. I was struck by the advanced stage of disease shown by some of these paranoid demented on admission, with vivid and abundant hallucinations. The disease had been developing in some for many months, and yet the patients had been able to carry on their duties without exciting remark. In this they differ from the paranoiac, whose delusions, even though unsupported by hallucinations, gain publicity more forcefully and at a much earlier stage. The enviable apathy of the schizophrenic during exciting air-raids was remarkable and occasionally indicated the diagnosis in a doubtful case.

*Melancholia*.—There were ninety-eight cases in which depression was the most important feature. About half were involutional or pre-senile melancholia, and were in no way different in pathology or symptoms from the cases met with in civilian asylums. The remainder were of a type not so common. They were younger men, æt. 25–35, and the

symptoms tended to merge either into "persecuted" paranoia or anxiety neurasthenia. The latter was the more striking symptom, and was almost universally present in the younger depressed cases. Fatigue seemed indicative as a causal factor in the anxious depressed group because of the remarkable improvement which took place in many of them after a week or two in bed, indicated not only by abatement of the symptoms, but also by ability to stand air-raids with comparative composure. It is probable, as Stanford Read points out, that most of the cases in which delusions are at all prominent should be regarded as primarily paranoiacs, with a secondary emotional depression. Domestic unhappiness or trouble was a common cause in this group. The soldier would appear to react to distress of this kind by depression and to occupational worries by paranoia.

*Mania.*—There were eighty-two cases in which manic excitement occurred. They included fourteen severe cases of classical acute mania, two of them associated with wounds, and twenty-six cases of acute excitement with more marked confusion and hallucinations. The remainder were subacute and more transient. Some cases in this group were probably hysterical dissociations with illusory dream states, but their violence and unreliability rendered it justifiable temporarily to label them as cases of mania. The two wounded were both severe cases, and showed wonderful recuperative powers. One of them, a most powerful man with an enormous sloughing wound of the calf, ran about the ward, and at various times scrubbed his wound with a nail brush and filled it with fæces. He made a good recovery. The hallucinated cases merged with those I have classified as confusional. Many of the milder degrees of excitement would no doubt turn out to be katatonic in nature.

Among the subacute cases were three curious cases of exaltation, with perfect orientation and lucidity, no motor, and little mental acceleration, no evidence of hallucinations, suffering from fairly severe mustard-gas burns. They were quite accessible, had no delusions, felt no pain or discomfort from their burns, as a rule most uncomfortable, and simply lay in bed and smiled approvingly at everything.

*General paralysis.*—I diagnosed general paralysis in twenty-one cases, all but one having globulin and a pleocytosis in the cerebro-spinal fluid. The signs of general paralysis are liable to be closely simulated by commotion neuroses. In my cases the average age of onset, thirty-eight years, was not earlier than in civilians, but the symptoms showed unusually rapid progress, most of the cases having a history of only a few days' illness. Probably the early moral deterioration was less noticeable in the Army than in home surroundings. One man had been a competent N.C.O. on a supply train, broke down completely after three days of the stress of the German advance in April, 1918,

left his unit, and was arrested walking among a group of peasant refugees wearing a pair of civilian trousers with his uniform, and carrying a dead fowl. He was markedly expansive on admission, and during the three weeks he was under my observation his speech became almost unintelligible, and general mental dilapidation became extreme. Stanford Read, working with a very much larger number of cases, states that he found the average age of incidence in soldiers very much earlier, and that a very short period existed between the syphilitic infection and the commencement of symptoms. As it appears that in very many cases of quite early syphilis the central nervous system is seriously affected without symptoms, one might expect to find that the stresses of war would increase and hasten the syphilitic cerebropathies.

*Alcoholic psychoses.*—Cases in which the symptoms were wholly due to alcoholic excess were very few. In twelve of my cases, or 1.25 *per cent.* only, was alcohol the immediate causal factor. Acute hallucinatory states, developed while on home leave or during the return journey to France, accounted for six, and the remainder were chronic intoxications. Eager found the percentage of alcoholic cases from the B.E.F. to be 1.1 over 1,652 cases, which agrees closely with my figures, whereas Hotchkis estimated that 18 *per cent.* of 831 Expeditionary Force cases were of alcoholic origin. The figures of other observers show similar striking disparity. Stanford Read, reviewing a very large number of expeditionary cases received at Netley, found the percentage of alcoholic cases “very small,” but quotes Lepine’s figures for 6,000 cases in the French army, in which he ascribed to alcoholic excess the astounding proportion of 50 to 66 *per cent.* Other French writers agree closely with these figures. Obviously the personal equation enters largely into the question, and different observers adopt different points of view. That alcoholic excess is a protection against imperfectly repressed mental pain is revealed by the most superficial analysis of the vast majority of so-called alcohol cases. In these alcoholism and its symptoms are secondary. Perhaps the most elementary example is that afforded by the self-conscious man, who takes a few drinks to render his social manner easy and confident, and to anæsthetise his feeling of inefficiency. The same applies to intoxications by other narcotic drugs. Temporary or prolonged absorption of such substances produces definite syndromes, which obscure the real psycho-pathological process. I would except only certain defectives who probably seek the elementary pleasurable sensation of intoxication for its own sake. The acutely hallucinated alcoholic cases provided three of the cut-throats. All the acute cases showed some depression and a distinct tendency to the paranoiac temperament and outlook. The chronic cases were all past middle age, and all rather pathetic failures :



a private soldier of twenty-one years' service, a master mariner of twenty-four years' standing cleaning motor bicycles, etc.

*Epilepsy.*—Of thirty-six cases who had had fits, I was of opinion that twenty-seven were epileptic. These included three defectives, two cases of head-injury, four cases of *petit mal*, eight cases with psychotic symptoms. Five of the cases had had pre-war fits. I judged the other ten cases to be epileptic from the nature of the fit, the time and manner of its occurrence, etc.

Modern observations point convincingly to the very indefinite differentiation between epileptic and hysterical fits. As the distribution and intensity of the motor discharge may be identical, it is not easy to see how a diagnosis may be made on such signs as cyanosis, extensor plantar response, etc. Many authorities base their diagnosis on the accompanying mental symptoms only, and others assert that the conditions are continuous with one another and not to be rigidly separated, which appears to be most probable. In certain cases of trauma, sometimes somatic, sometimes psychic, resulting in the blocking or closing of many paths of outlet, either structurally or by inhibition, according to the theory of White and Jelliffe, there occurs a periodic discharge of energy of a certain intensity, and accompanied or followed by a certain degree of dissociation. This dammed-up and suddenly liberated energy may be of the most elementary type, or it may be sublimated and take a more purposive form, such as oneiric delirium, *furor epilepticus*, or any epileptic equivalents. Epileptic automatism is in itself indistinguishable from hysterical somnambulism. It is probable, too, that *petit mal*, tremors, tics and habit spasms differ only in degree from the major manifestations, and constitute vents for energy denied its proper outlet. The objectionable egocentricity of the chronic asylum epileptic is merely another aspect of the fit—equally mis-directed.

*Psychasthenia.*—I have included in this class only the constitutional psychopaths, of whom there were seven. They presented no features of interest.

*Stupor.*—There were five cases which appeared to be manic-stupor. There was no history of concussion, undue emotional stress, or fatigue; there were no hallucinations, and recovery was gradual, without dipping of consciousness. Two of them, apparently in deep stupor, trembled violently during air-raids. A number of cases exhibiting greater or less degrees of stupor are included under the headings of "dementia præcox" and "neurasthenia."

*Various.*—In addition to the above, I had one case of senile dementia, an Irishman, æt. 68; one case each of tubercular and cerebro-spinal meningitis (the former died); two cases of varicocele with hypochondriacal and psychasthenic complaints; three cases of

chorea; three of tabes; two of cerebral syphilis; one of severe cranial neuralgia of uncertain origin; and one chronic morphia taker.

*No appreciable mental disease.*—Twenty-two cases were admitted in whom no nervous or mental disease was discovered. Of these, in my opinion, only five were deliberate attempts to feign insanity, or 5 *per cent.* of all admissions. Two were deserters and have been mentioned under the heading of prisoners. One stole a sum of money from a comrade, posted it to his fiancée, and had a good time on his next leave. He pleaded amnesia for the theft, and stated he had suffered from and had treatment for similar losses of memory all his life. On reference to his relatives this was shown to be false. One while waiting discharge from hospital tied a handkerchief to a stick and marched about in a foolish way. On examination he was tremulous and on his guard, and soon broke down and became ashamed and repentant. One charged with desertion and theft, after spending some weeks in prison, suddenly reported that he had suffered all his life from headaches, and that at the time of his offence he was unconscious of what he was doing. He had no amnesia or signs of nervous disease. He was unable satisfactorily to explain why he had not reported sick sooner (he had served other sentences without complaint), and I was satisfied he was exaggerating his disability.

In none of these cases did I lay a charge. Four already had sentences to face, and the other appeared so genuinely ashamed that a scolding appeared to meet the case. Five more in this group had been guilty merely of silly or unusual conduct which was not in my opinion pathological in origin. One case, perhaps, deserves mention. He was a youth, æt. 19, only son of a widow, his father, a drunkard, having died sixteen years ago. The boy had been sent to a good school and took every possible prize, but he had never played a game or had a friend, or spent an hour, except at school, away from his mother. He was a voracious reader, and had a really good education, though his knowledge of affairs was poor. He was living at home completely wrapped up in his mother, when he was hurled into a conscript camp. He was reserved and sensitive and could not bear the rough ways of the men, nor join them in their work or pastimes. He had flickerings of a desire to improve his wretched condition, but wept when one spoke of manliness, etc., and pleaded to be sent back to his mother, with whom he corresponded almost daily in very affectionate terms. Physically he was slight and poorly developed, but neither infantile nor effeminate. I have never seen the œdipus-complex so near the surface. As the armistice had been signed and there was little chance of his coming to harm, I sent him forth to look for his manhood once more. The remaining twelve cases in this category were transferred to medical

wards on account of minor physical ailments. I was unable to discover on what grounds they had been sent to a mental ward.

*The psychoneuroses.*—I returned 134 of my patients as suffering from psychoneuroses. These were nearly all fairly severe cases, as only those exhibiting psychotic symptoms were supposed to be sent to my wards. I would further classify them as follows :

States of anxiety . . . . .	52
States of confusion, delirium, and stupor . . . . .	34
"Neurasthenia" . . . . .	13
"Psychasthenia" . . . . .	10
Conversion hysteria . . . . .	16
Hysterical "fits" . . . . .	9

These groups are by no means mutually exclusive. Many bringing a history of temporary dissociation presented symptoms only of anxiety, and others made this change under my eye. All the "conversion" cases and some of the "fit" cases displayed greater or less anxiety. Further, the cases shown here merged with those returned as melancholia, confusional insanity, etc.

The ætiology and psychopathology of the war neuroses have engaged much attention, and many different views receive support. Exhaustion *per se* as a causal factor would appear to be definitely excluded not only by the experience of Bonhoeffer with the Serbian Army, but by the observations of Maitland, Farrar and others with our own. The other materialistic theory of causation, that of commotion or trauma, advanced principally by Mott, does not appear to afford a complete or satisfactory explanation for the multiplicity of neurotic phenomena which occur. The unimportance of concussion and fatigue factors is also generally supported by German experiences as given at the Munich Congress of 1916 and elsewhere. Evidence is growing on every hand of the paramount importance of the psychogenic factor, but it is probable that fatigue and exhaustion, commotion and emotion participate in varying proportions in the ætiology. MacCurdy, who gives first place to the psychogenic factor, distinguishes between physical and mental fatigue, and gives due place to commotion. Hurst differentiates between cases the result of exhaustion and those following prolonged emotion, but it appears unlikely that the latter can be separated from a considerable degree of fatigue.

In my experience many cases ascribed to each of these causes occurred, supported by evidence of varying degrees of value ; a man's own statement as to how near he was to a shell-burst is wholly untrustworthy, and the greatest caution is required in the interpretation of the word "buried." I was quite unable to trace any connection between the apparent cause and the form of the neurosis. For example, two

cases admitted as "N.Y.D. ? Mental" and showing typical anxiety states, were afterwards classified as "shell concussion" by the official Army form, made out by neurologists in the front area after reference to the patient's units; and as stated above, the symptoms of individual patients altered completely while under my observation.

I will now discuss separately the various groups into which I subdivided the psychoneurotic cases.

*States of anxiety or "Angst."*—In this group I placed 52, or 39 *per cent.* of the whole. Their symptoms have been exhaustively described by McCurdy and others. All degrees occurred, from simple "jumpiness" without conscious fear—a state well recognised by all soldiers—up to a condition of agitated melancholia. Some had developed gradually and without incident, others showed marked exacerbation after an unpleasant episode, others followed a phase of confusion or stupor. In all evidence of prolonged and increasingly powerful emotion was to be found. Insomnia, painful hypnagogic hallucinations, battle-dreams and nightmares were common. The terror shown by some during air raids was pitiful and out of all proportion to the conceivable degree of danger, and was, I think, due to conscious or unconscious abandonment of all attempt at control. I have noticed that all soldiers tend to make more fuss about an air raid at the Base than about the same degree of noise and danger at the Front.

Distortion occurs very rarely in the battle-dreams and deliria of neurotic soldiers, but in two cases—both young boys—dreams of amorphous black and green monsters occurred. In the case of Pte. S—, described under "suicide," slight distortion was found. When the neurosis is at its height the patient is always defeated in his dream combats, but as he recovers he begins to turn upon his nightly attackers, and in the end to drive them before him in flight.

Physical signs of hyperthyroidism occurred in just half of the anxiety cases and were extremely prominent in a few. The apparent degree of hypersecretion by no means corresponded to the severity of the mental symptoms. Exophthalmos and enlargement of the gland were rare, but tachycardia, sweating, the pilomotor reflex described by Hurst, tremors and hyper-excitability were common. In mental symptoms these did not differ from the cases showing no signs of increased secretion, which had probably been present at an earlier stage. Some of the more severe cases had obsessive ideas towards suicide, and all had a dread of insanity.

Few of these cases made any real progress while in my ward. As regards treatment, I cleared up amnesias when possible, and in most cases made use of therapeutic conversations and superficial analysis, but the presence of definitely "mental" patients, the air raids, and the loss of self-control shown by so many made my results poor. Such



cases should be retained in the Front area, or evacuated completely out of reach of the alarms of war.

*States of confusion, delirium and stupor.*—Of these I had thirty-four cases. They merge with cases described as confusional insanity, and include a large number of conditions difficult to distinguish clinically or causally. Simple retardation, simple confusion, confusion with stupor, and confusion with a vague and imperfect dream state are among the phenomena observed. As regards the forms produced by concussion, I place so little reliance on the histories of most of the cases that I am unable to venture an opinion. The patient himself is naturally unable to distinguish between an amnesia and a period of unconsciousness following a blow. MacCurdy states that low mental tension and dipping of consciousness are pathognomonic of concussion types, but I found both symptoms where concussion could with reasonable certainty be excluded. In the following cases concussion and physical exhaustion do not seem to have occurred, and the syndrome resulted solely from prolonged emotion :

Pte. L—, æt. 29, four years' pre-war service. In October, 1914, was on patrol with three others. They realised they had got too far ahead and were among Germans. They lost their heads and kept pushing on, gradually divesting themselves of kit, concealed in ditches, etc. After going some distance they found some civilians and succeeded in getting into plain clothes. They had now some idea of getting across country to Antwerp. They had some hair-breadth escapes—once lying on a haystack while a German party lunched at the foot—and got separated. The patient pushed on alone and got into Lille. He could speak no French, and was taken in by some French people and sheltered in a garret. He was fairly well fed, and later a forged *billet d'identité* was obtained for him. He had once been a cobbler, and was able to earn some money repairing boots, occasionally got out and had some exercise. He lived naturally in a constant state of dread and anxiety until the British entered the town. With other escaped prisoners of war he was sent to hospital. Early next morning he passed into a dream state, got up, partly dressed, and began musketry exercises, presenting arms, etc. He remained somnambulistic till admission, when he was apprehensive, disorientated, and quite imperceptive, inclined to resist attention blindly, and was suffering from retention of urine. He lay with eyes fixed unseeingly, periodically raising his chest in opisthotonos, and rolling slowly round to the left till he would have fallen from the bed. He was able to swallow. He slept at intervals for forty-eight hours, and then began to have short lucid intervals, but with considerable retardation. He took some interest and was able to give his particulars. He cursed the Germans with violence. The stuporose condition kept recurring, when the same opisthotonic movements were repeated. After several days only was I able to get his history, and during his account he passed into a somnambulistic state, going through in pantomime the experiences of his original flight, crawling about the floor, peeping over tables, etc. He remained unstable till his transfer to England if questioned about his

captivity. A complicating causal factor was his fear that he might be regarded as a deserter and punished.

The following case of hysterical dissociation with hallucinations appears to be worth recording at some length :

Gnr. W—, a Canadian, æt. 21, service two and a-half years ; precocious boy and youth. Studious, clever, eccentric, not a social. Worked with father, who was an analyst, etc. Learned French, chemistry, etc. Quarrelled with father and twice ran away, getting employment as “boots” in hotels. Precocious sexual experiences. Ran away from university and enlisted. Got on well ; was promoted to sergeant. Transferred to University unit as gunner and came to France. After eleven months with battery was rendered unconscious by a bursting shell. Had had no premonitory signs of neurosis, and had felt happy. Seemed shaken, and was sent to his transport lines for a rest. Began to have impulses to do silly, senseless things ; these he recognised as abnormal, and was, as a rule, able to resist, but committed some profitless petty thefts. Began to have the idea that he had been a spy. At first realised the absurdity of this, but later conviction became intense, and hallucinations and a state of anxiety developed. Could hear his chums saying he was a spy, and ought to be shot. About this time he was sent down to a neurological hospital. He began to consider himself a martyr, thought what a fine thing it would be to be shot as a spy, how all his friends, and especially his father, would be startled, and think more about him, and so on. He also enjoyed the idea that someone would get into trouble if he was shot unnecessarily and the mistake came to light. At this point he reported himself as a spy, giving a most circumstantial account. He stated that as a “boots” he had got into the power of a German agent, who had used him for years. He described how he sent his information to a Mons. F— in Paris. (By a remarkable coincidence a German agent named F— happened to be known in Paris at this time.) He attracted considerable attention. After a few weeks the hallucinations ceased, and the patient realised his position. He confessed to his fabrications, and after some delay was sent to the base. Consciousness was complete on admission, and he had no amnesia. He gave me his history in an ashamed and humble way. His conduct was natural. He was still liable to impulses, however, usually to petty thefts, and on two or three occasions rifled the lockers, replacing the plunder shamefacedly later. He had an impulse to poison himself, partly to be a martyr, partly to cause a fuss. He had several dissociations with hallucinations, in which he heard me describing him to the sisters as a spy, and saying he would have to be shot. These attacks began with headaches, and passed on into deep sleep. It is interesting to note the recrudescence of the “spy” idea with a totally different emotional colouring. Between them the patient showed an ego-centric vain temperament ; he was proud of his knowledge of French, etc. ; fancied himself as a writer of prose and poetry and as a lady-killer, and on the whole was rather pleased with his illness and the attention it had attracted.

A case similar to the above is described by Dr. W. S. Dunn, in which the patient made two attempts at suicide, and my own case, Pte. S—,

described under the heading of suicide, is of the same type. Unfortunately the probable degree of dissociation, as shown by resolution in the suicidal attempts, is not discussed by Dr. Dunn, nor is the degree of amnesia. All these cases sought to appear in a romantic and interesting light, and to attract attention and notability. In a case reported by D. K. Henderson the same object is visible, but in this case there was apparently no dissociation or somnambulistic state at all.

There would appear to be an infinite gradation between a true somnambulism followed by amnesia and a simple paramnesia, with pseudologia phantastica occupying an intermediate position. It is also probable that somnambulisms also show degrees according as their content is purely delirious or hallucinatory, or distorted and illusory. Towards the lower end of the scale one finds such cases of confabulation as that described by Henderson—the “white lies” of children, and the genuine distortions of memory which are familiar to all. (The externally changing paramnesiæ of an alcoholic probably arise from a different mechanism.) The degree of conviction or self-deception in all these grades is a most interesting problem. Obviously it is inadequate to call a man a “liar” who is willing to stake his life on his beliefs. I do not know if the psychopathology of the lady who confabulated the story of the “Dundee nurse,” or of the journalist who “visited” the Russian armies in Belgium in October, 1914, has been reported, but they seem eligible for inclusion in this class.

In the following case the dream-content took an unusual form, the patient's attitude being very like that of the acutely hallucinated “persecuted” paranoiacs. Probably similar mechanisms were at work.

Pte. B—, French-Canadian, one year's service, one month in France. On his first trip to trenches a few shells passed over and burst some considerable distance away. He fell down, look wildly round, trembled, refused to speak or walk, and was finally carried to an aid-post. In the C.C.S. he became very excited and violent, attacked orderlies and other patients savagely, and was hurriedly transferred to the base, labelled “mania.” On admission he was extremely suspicious, glared around, resented any attention, but did not resist, and remained silent. He seemed to have a severe headache. He was microcephalic, and had a low, cunning, vicious face. He paid no attention to the sisters, was suspicious of orderlies and other patients, and glared furiously at anyone who went near him, but allowed me to examine him, occasionally answering in a low monosyllable. He lay beneath the bedclothes, ate and slept well, smoked, kept himself clean, would not help to carry out his own bed to the garden, refused all information about himself. He was put on small doses of bromide and aspirin for his headache, which seemed severe. After a few days he made a violent and quite unexpected attempt to strangle me, and it taxed the strength of four men to control him. His lips were retracted till his incisor teeth were entirely exposed, he shook violently, and his face was contorted with fury. He made several other attacks upon me, but was always more easily

mastered. Fortunately he relaxed his suspicions of the orderlies correspondingly. He made attempts on two occasions to assault a distinguished visitor, a Lieutenant-Colonel, R.A.M.C., who was interested in him. He was in the same mental condition when transferred to England. I failed to get into touch with him, but I should like to have known with what he identified me in his illusory world.

In the majority of these cases the delirium, etc., was of short duration, and disappeared in a few days. Active interference was impossible, and there was nothing to do but wait. Some of them, as the integrity of their consciousness was restored, tended to develop states of anxiety or "conversion" symptoms. The latter were easily dealt with and prevented, but as a rule little impression could be made on the former.

In four of the cases in this group the stupor was deep enough to be considered narcolepsy. In others the stupor was less, and was combined with confusion. In all recovery was quite sudden.

*"Neurasthenic" states.*—Using the word in its popular sense, in this group I placed thirteen cases complaining of headache, fatiguability, weakness, and general bodily ailments. Two were cases of neurasthenia proper. Both were over forty, had suffered for many years, had had light comfortable billets at the base. In the others the occurrence of battle-dreams showed them to be true war neuroses lying intermediate between the conversion hysterias and states of anxiety.

*"Psychasthenic" states.*—These are to be distinguished from constitutional psychopaths. There were ten, the symptoms being diffidence, indecision, loss of concentration, etc.

*Conversion hysterias.*—I had sixteen cases of conversion hysteria, all mutism, three with deafness. Tremor is a common conversion symptom but is usually associated with anxiety. Stammering was rare, and appears to be a symptom of late development. Five were relapsed cases, and all responded at once to treatment. They displayed more distress at their condition, and greater relief at its removal. Two were cured by hypnosis, and the rest by persuasive suggestion.

In addition to these I had two cases of hysterical vomiting, combined with other psychoneurotic symptoms.

The following case illustrates the combination of conversion and delirious symptoms in the same patient:

Pte. B—, æt. 19, service three years eleven months. Married. Professional boxer. Exceptionally well-built boy. Blown up four months previously, with mutism, deafness and an amnesic period. Recovered voice and hearing by suggestion, but still stammered badly. Relapsed after air raid while in convalescent camp. Admitted in a state of great terror and excitement, confused and disorientated, shouting and crying aloud. Vivid hallucinations and illusions of Germans advancing on him with rifles, etc. Fought and struggled violently, and was given hyoscine and morphia. Had some hours' sleep and woke apprehensive,



but more composed, and deaf and mute. Hallucinations returned at intervals, but illusions ceased. Orientation returned, and we were able to approach and soothe him. On the third day I restored his hearing and speech, but he had a violent inspiratory spasm, which made the latter most painful. Later I was able to remove this, so that he could speak freely in a low voice. His delight was unbounded. He had amnesia for his excitement on admission. For two days he seemed stable and well, then suddenly and for no apparent cause his dream-state returned, he had the same terrifying hallucinations, and he had to be held down. He cried out, showing the same severe stutter. After half an hour he came to, with a hazy memory. After this he was uneasy, nervous and apprehensive, and needed constant encouragement. He had a restless, suspicious night. He told me he kept seeing Germans everywhere, pointing rifles and bayonets at him. These were not illusions, but pseudo-hallucinations. He improved steadily, but for some days was subject to the pseudo-hallucinations with short intervals of dissociation and real hallucinations. I have not seen these combined in this way in any other case. A few nights before he left for England he went through a noisy air raid tremulously, but without ill-effects.

*Hysterical fits.*—I have already discussed these cases under the heading of "epilepsy." There were nine cases of convulsive attacks, obviously hysterical in origin.

*Conclusions.*—(1) A consultant psychiatrist, understanding and having sufficient authority to protect the interests of those suffering from mental disorders, is essential. Such a post, held up to 1917 by Lieut.-Col. C. S. Myers, R.A.M.C., was afterwards abolished or left unfilled. The accommodation in the mental wards at Boulogne compared unfavourably with that provided for surgical and medical cases, and when seven out of the twelve trained mental attendants were combed out in 1918 no attempt was made to replace them by trained men of lower category, numbers of whom were available, but totally inexperienced men were sent. This obviously increased very considerably the risks in the safeguarding of three score acute mental patients, apart from the fact that only one single room, provided with a door, was available.

(2) No special "war-psychosis" was evident, but the proportion of acutely suspicious and persecuted delusional cases noted by various writers was certainly higher than in the same number of civilian cases.

(3) The patients were admitted at a much earlier stage than is usual with civilians, and their psychotic symptoms were, as a rule, correspondingly more responsive to treatment. On the whole, however, I found soldiers in acute excitement, confusion, etc., very much more amenable to external influences than the same types of patients in a county asylum. The ideas of discipline and rank are thoroughly stamped in during training, and are slow to disappear. It is difficult to see how such drastic interference with personal liberty as compulsory

detention in a mental hospital could be arranged in civil life without some safeguard analogous to certification, but there is no possible doubt that earlier treatment of mental disorders is urgently called for, and must be made more easily available than at present. Further, curative mental hospitals should be kept completely distinct from repositories for the defective and the organic dement. The influence upon the temporary and curable psychoneurotic of daily mixing with the gravely deteriorated chronic insane cannot but be harmful.

(4) Little psycho-analysis was done, but all cases were interrogated in private, simple explanations of psychological mechanisms given where suitable, and superficial analysis on the evidence of dreams, association tests, etc., were carried out, with satisfactory results. Many of the depressed and deluded cases had little conviction, and were remarkably susceptible to persuasive suggestion. Hypnosis was used rarely and less frequently in later months. Other means of overcoming psychic resistance, if slower, are more satisfactory. All patients were in the open air every possible hour—labour was plentiful, and the beds were light—and everything was done to foster the hospital atmosphere. I was fortunate in being able to maintain a spirit of orderliness, of self-control, and of "will to recover," which was of the greatest possible assistance, and which of itself was responsible for most of the improvement which occurred in the patients.

(5) Neurotics and psychoneurotics, if allowed to leave the Front area for treatment, should be sent out of risk of all the alarms of war. Their treatment in a base, exposed to air raids at short intervals, is extremely difficult.

(6) Defectives, if enlisted at all, should be retained strictly for home service.

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“*Psychic Secretion: The Influence of the Environment.*”<sup>(1)</sup> By LIEUT. COL. E. P. CATHCART, M.D., R.A.M.C., Professor of Physiology, London Hospital Medical School.

MR. PRESIDENT, LADIES AND GENTLEMEN,—Probably most of what I shall say to you this afternoon will be well known to you; indeed, many of you may think the information self-evident and trivial, but in spite of this I hope that what I say may serve to re-emphasise in your minds the fact that we are all very subject to our environment.

Consciously or unconsciously we are all inclined to look upon mankind as a superior caste of living organism—a something which occupies a place apart in the kingdom of the living. But this assumed divergence from all other life arises solely from the fact that some few of mankind think or pretend to think, and therefore have not unnaturally arrived at the view, that mankind is a class apart. We recognise and state in a superior sort of a way that the lower living organisms are subject to their environment—are indeed at the mercy of their environment, that their actions and manner of life are governed by their surroundings.

Yet in spite of our superiority we, too, as a class are subject to, and in fact one might almost say are victims of, our environment. We respond to the various types of stimuli which affect the despised lower members of creation, but unless we respond in a way divergent from the conventional social standard of conduct, we pursue the even tenor of our way almost blissfully unconscious of the fact. On the other hand, if we respond irregularly, or too actively, we immediately attract the notice of our friends, mayhap of the alienist, and sometimes even of the police.

Now, some of you may quite correctly inquire what has all this wordy preamble to do with the subject of my lecture, “Psychic Secretion.” I would reply that it has everything to do with it. The so-called psychic secretion is only a demonstration of one of the simplest of the relations which we have to the outside world. The commonly used term “psychic secretion” is really a misnomer; all it is, in reality, is a reflex secretion in which the stimulus is not the usual commonplace one.

Let us for a moment consider the type of secretion to which the term

"psychic" has been applied. It is common knowledge that under certain conditions, quite apart from the taking of food, our "mouths water." This mouth-watering was not considered worthy of the attention of physiologists until Pavloff—in whose laboratory at Petrograd I had the honour of working—took up the matter, and thoroughly investigated the conditions associated with salivary secretion. Pavloff first of all showed that it is not the mere flow of saliva which has to be considered: the composition of the saliva which results is also under control. If you tempt a dog with a mass of raw meat it gets very excited, but no saliva is secreted from the parotid gland. But show it dried meat powder, or dry bread, and immediately there is a free flow of watery saliva from the parotid gland. If, on the other hand, you are making observations on the submaxillary gland, and you show the animal the raw meat, a free secretion results. Pavloff then demonstrated that the different salivary glands are very sharply differentiated as to the conditions necessary for their activity; they show a marked selective action in the choice of an adequate stimulus. A very interesting point is, that the mechanical stimulus in the form of a material object is not the only potent stimulus.

The psychic stimulus is not confined to the salivary glands. Pavloff has demonstrated that the gastric glands react in the same way, thus confirming a very early observation of Bidder and Schmidt, who had noted that the offering of food to a hungry dog evoked a flow of gastric juice. The interesting fact about the gastric psychic secretion is, as Pavloff has clearly demonstrated, that the latent period of secretion is identical—*viz.*, five minutes—with that which follows the normal stimulation of the buccal mucous membrane. Pavloff further showed that the temperament of the animal tested plays a large part in the flow of the gastric juice. Lazy or impatient animals do not act as good subjects.

One of the practical results arising from these experiments was the conclusion that the taking of food is, or should be, a serious function; unless the meal is eaten with interest and enjoyment the full value is not obtained. Hence we are, indeed, at the mercy of our environment. It is not the mere food which is of primary importance; there are many additional factors which play an important part in this question of the taking of food. The refinements of life in our prandial ritual have gradually assumed a position of primary importance. Under normal conditions most of us make certain demands in connection with our meals: spotless linen, bright silver, a well-decorated table, and everything set in a special room. Unless we get this, along with well-flavoured, well-cooked, and well-served food, our appetites are apt to fail. Hunger is indeed the best sauce, but indoor work is not the best stimulus for the creation of hunger.

But there is still another side of the question, and this is an aspect



which you here will appreciate perhaps more fully than I can, and that is the effect of mental strain or emotion on the appetite. We all know how often, when we are deeply interested in a piece of work, the usual meal-hour can come and go, and yet we are indifferent ; or, on the other hand, how strain and worry literally destroy the appetite—the food may be taken, but it is eaten without enjoyment or interest, and the all-important psychic secretion fails. Or still further, we may be heartily enjoying a meal when some emotional storm sets in—say a quarrel starts, the temper is raised, and as a result of the violent emotion the digestion is actually brought to a complete cessation. Truly we are at the mercy of our environment. We respond to stimuli which of themselves play, and can play, no first-hand part in the secretion of the digestive uses, but yet which, in conjunction with a very early reflex, can be gradually converted into true stimuli of the first order. In other words, we form secretory habits, and unless the particular concatenation of events is present, or unless certain well-defined specific stimuli are present, the result is failure. You, above all other workers, appreciate the true importance of these apparently subsidiary factors in the realm of psychopathic studies—how certain individuals must have certain stimuli before what may be regarded as a perfectly normal act can be performed. Take for example a certain well-known speaker. What would he do if coat-lapels went out of fashion and his tailor failed to provide them ! Then take those individuals who cannot speak without having something to play with. The stimulus of the coat-lapel or the piece of string, in themselves perfectly indifferent, and perfectly incapable of forming adequate stimuli for thought and speech, yet play a very real part in the smooth flow of thought and speech.

The facts underlying this reflex secretion have been investigated by Pavloff and his pupils, using the secretion of the salivary glands as the test. Pavloff carried into the realm of the central nervous system the methods of experimentation which had given such successful results in connection with mere glandular activity. The particular methods which he employed he has called the formation of “conditioned reflexes.” He divided the salivary reflexes into two classes ; he spoke of the “conditioned reflexes” and the “unconditioned reflexes.” Pavloff would say that the so-called psychic secretion which resulted from a stimulus, perhaps indifferent in itself, was a conditioned reflex, whereas the ordinary stimulation of the buccal cavity on the taking of food—the normal way in which saliva is caused to flow—he calls the unconditioned reflex. From a study of these two reflexes Pavloff has evolved a wonderful method of gaining information about our relationships to the external world, that is, of our relationship to our environment.

In developing this relationship there are two fundamental mechanisms involved. The first is by what he called “temporary association”—that

is to say, the bringing of external phenomena into relation with the reactions of the organism, this connection becoming more and more complex and the more subject to modification or influence as evolution of the higher centres proceeds. The other fundamental mechanism is that associated with the "analysers" usually called the sense-organs, *i.e.*, the eye, the ear, etc., the organs which sort out the many and complicated stimuli which bring us into relation with the external world.

As one of the simplest and most primitive of our relationships to the external world is the necessity of procuring food, in the course of the quest for a suitable supply of nutriment the means by which food is detected increase in number and complexity as the analysers are differentiated. As a result the variety of phenomena which gradually become associated with food increases in number, so that in the end, owing to the variety and number of the adequate stimuli, the impossibility of other than mere temporary or evanescent association is obvious.

How is the conditioned reflex—the formation of the temporary association—brought about? How is an indifferent stimulus converted into an active one? Why is it, for example, that one man reading in a newspaper—an indifferent stimulus—that coupons are no longer required for meat in a restaurant has, if he is a lover of a well-grilled steak, an anticipatory flow of saliva, whereas a man who is a vegetarian is left cold, except, perhaps, for a feeling of disgust that more meat is to be liberated, by the same announcement.

Pavloff showed that if a new indifferent stimulus be presented sufficiently often in conjunction with one which is known to cause a secretion, in the end the indifferent stimulus presented alone will evoke a response. It means that the reflex arc has taken on a new afferent neuron, but it has not taken it on unconditionally; the path is not yet beaten down hard: no right-of-way has been formed.

I shall now give you an account of how an indifferent stimulus may become a true reflex. Take, first of all, an example of an unconditioned reflex. As you know, if you give an animal food saliva will be secreted. Suppose, now, that every time food is given to a dog—for example, meat powder thrown into its mouth, so as to leave out the factor of chewing—a bell is rung, or a light shown, or a single note sounded on an organ, or the dog has its skin scratched on a particular spot. If the giving of the food and the application of the particular stimulus selected be made to synchronise a number of times—the actual number varies a good deal with the individual dog—it will be found that one day the superimposed indifferent stimulus, the ringing of the bell, if that were chosen, *used alone*, will evoke the secretion. In other words, a conditioned reflex to a specific stimulus has been created.

This is an example of the genesis of a conditioned reflex, and similar reflexes can be generated by practically any phenomenon of the external world, provided the animal possesses a suitable analyser or receptor—that is to say, if it can form temporary associations between the external phenomena and the mechanism for the salivary secretion.

The point that is thus emphasised is that, provided a well-established primitive unconditioned reflex exists, by suitable treatment a previously indifferent external stimulus can be brought into intimate relationship with it.

The investigation would be very simple if it all ended here, but Pavloff has definitely shown that the problem of inhibition must be considered: that not only can one inhibit either externally or internally these reflexes, but in the end an inhibition of the inhibition may be brought about. Any external phenomenon may act under suitable conditions as an inhibitor. This fact is of serious import when the conditioned reflex is being developed in the laboratory: the experiments have to be carried out in dead silence every day; each time one has to use the same movements. Very frequently the very slightest outside disturbance—the banging of the door in another laboratory, for example—is enough to upset the experimental dog for the day.

The question of internal inhibition is much more subtle. When a conditioned reflex is properly developed, *i.e.*, when the indifferent stimulus alone evokes a response, if the animal is not presented on several successive tests with the food which it has learned to expect on the application of the stimulus, the conditioned reflex ceases to be effective. As a rule this type of internal inhibition is merely temporary, the conditioned stimulus being effective at a later period.

At the same time actual inhibition of secretion can be developed by suitable treatment—that is to say, we can build up reflexes for non-secretion or non-activity just as easily as we can build up a reflex for activity. It is a matter of training, and of the utilisation of special methods.

In one animal under observation we had developed on its fore-leg a little active spot which, when brushed, caused active salivary secretion. In the middle of its back, on the contrary, by a similar process we had developed an inactive cold spot, and when that spot was chilled inhibition of secretion took place; it was a spot trained for non-secretion. If the non-secretion reflex is first evoked, naturally there is no flow of saliva; if the active reflex is now called in there will still be no flow—active inhibition has taken place. The active stimulus, however, soon becomes effective again. You get the same thing if you try to present two different active reflexes simultaneously, or if an attempt be made to superimpose an active stimulus during the period of secretion produced by another active stimulus.

It can also be demonstrated that the time element may play an important part. I have mentioned that in regard to the gastric flow there is a normal latent period of five minutes. A similar latent period may be developed in connection with conditioned reflexes. For instance, if in building up a conditioned reflex the food be not given until a definite constant period—say two minutes—after the application of the stimulus, it will be found that when the new conditioned stimulus is given alone there is a latent period of the duration established during the formation of the reflex, *viz.*, two minutes. During these two minutes of latency an active inhibition is going on to prevent the secretion of saliva. If, during this latent period, you throw in another perfectly indifferent stimulus—a stimulus which of itself would not produce a flow of saliva, one which the animal has not been trained to respond to—an active flow of saliva takes place; the indifferent stimulus has broken the spell, it has inhibited the inhibition, and an active flow of saliva ensues.

In dogs at least the development of a conditioned reflex is a very sensitive affair. Supposing you train an animal to the stimulus of an organ note of exactly 100 vibrations per second, that animal will be indifferent to a note of ninety-six vibrations on the one hand and to a note of 104 vibrations on the other; but as soon as the 100 vibrations are resumed the saliva flows again. Again, take the skin. One does not look upon the skin as in any way too sensitive when spacing it out with an æsthesiometer; yet the removal of the stimulating electrode or brush to a distance of only 1 cm. from an active spot will suffice to do away with the whole reflex.

Even painful stimuli can be used for the building up of conditioned reflexes. Thus an electric current strong enough to cause signs of pain in an animal may be built up into an apparently non-painful conditioned stimulus. If each time such a stimulus is used the dog be given food, it will be found that after a few repetitions all signs of pain from the stimulation have disappeared and a free flow of saliva occurs: the stimulus has lost its power as a painful agent. But move the electrode even a centimetre away from the spot and the dog will again show every evidence of violent pain. It must be admitted it is only with difficulty and under special conditions that you can develop these painful stimuli into good conditioned reflexes.

I think you will now see why I have insisted that we are victims of our environment—of the daily routine which is so dear to us; how it is that as we “get used” to a certain setting, we work better and more happily, we enjoy our food better—in general we are more comfortable. All these little amenities of our social life which we have come to look upon as more or less essential to our comfort and well-being are but indifferent stimuli, which, through constant application, have been converted into conditioned reflexes. Our environment plays such an



enormous part in our happiness and well-being simply because we have physiologically developed conditioned reflexes.

Sir ROBERT ARMSTRONG-JONES said this paper was a very difficult one to discuss. It was *ex cathedra*, and in attempting to discuss it one was apt to wander off into platitudes. It was well known that if one's morning letters brought bad news, one did not want one's breakfast. As the Psalmist said, one's tongue clove to the roof of one's mouth, and altogether there was an inhibition of psychic secretion. He felt very grateful to the reader of the paper for having introduced a very charming phrase, which he hoped Colonel Cathcart would not regard as his copyright—namely, "the prandial ritual." It described very aptly all the social amenities and conventions which appertained to the taking of food. He had always said that the poor man and the rich man drank for two opposite reasons—the poor man because he mistook the feeling of stimulation imparted by a glass of beer for the satisfaction produced by a well-grilled chop, whereas the rich man drank in order to make his meal a better meal. The latter had all the æsthetic reasons around him—the charming napery, the brilliant silver, the flowers arranged before him—he had practically all the nice amenities, and there was also the sight of the champagne bubbling in the glass. All those were points which had to do with psychic secretion. He was greatly interested in the fact that man was so much looked upon as a creature of environment. Man, however, was only an ordinary creature, not a superior mortal, but he had five or six windows to him, through which boundless energies came to him from without. We were, no doubt, deaf or blind or insensitive to many of the forms which came in, but we were open to others. He maintained that one was kept going by one's environmental stimuli coming from without. He had seen many men who retired at 60, having made their pile, and he had seen them "drop out of life," so to speak; they had become members of an asylum population merely because they had retired and no longer had the customary environmental stimuli. But there was one point he could not harmonise with what the reader had said. Dementia præcox was the unemotional type, but the subject of this never failed to secrete his saliva and never failed to grow fat in the early stage of his dementia præcox. He also appreciated everything which came before him. If humanity was so much the creature of psychic secretion, why was it that in this characteristic form of insanity all the functions of the body seemed to go on satisfactorily for a time? It had been a most excellent psychological lecture, touching on similarity, contiguity, the power of appeal to the cortex to inhibit all these things. One heard and read of various stigmata produced by thought and by suggestion. There was the question of the fine balance kept between the internal secretions. Perhaps it was the want of that balance which made Napoleon grow fat and sleek, and develop adiposis dolorosa. The same thing probably obtained in abnormal conditions of the thyroid. He had heard it said—and he had no reason to doubt it—that certain cases of goitre had been brought on by mental stress. Not infrequently he had seen neurasthenia in a shell-shocked soldier who had had goitre produced, perhaps by nervous influences. We had in our hands the creation of our own internal arrangements, and perhaps gigantism, acromegaly, goitre and similar conditions could be controlled if the inhibition were exercised. He had been well rewarded in coming to hear the lecture.

(<sup>1</sup>) Read at the Quarterly Meeting of the Medico-Psychological Association held in London on February 20th, 1919.

*The Genesis of Delusions: Clinical Notes.* By COLIN McDOWALL, M.D., Medical Superintendent, Ticehurst House.

MEN and women hold to and have faith in certain opinions as the result of long thinking around and along certain lines. Our social and political tendencies are the outcome of an analysis more or less critical, and believed by the individual to be impartial. A scattered phrase or an apparently insignificant incident may attract attention, and be the beginning of a prolonged mental conflict which is finally determined by a definite line of thought. It does not follow that the reasoning is always logical, or the argument conclusive to people of other opinions, but nevertheless a conclusion is arrived at, and it is final.

How this is borne out in every-day life may be seen in the following narrative: A boy of Scotch descent, bearing a distinctly Scotch name but born in Ireland, was sent to a school in Scotland. His school-fellows pronounced him an Irishman at once. His accent was Irish, and he lived in Ireland, so his Scotch school companions would not admit him as a Scot though his parents had always fostered the idea that he was one. The view of his school mates was a rude awakening. When the International Rugby matches take place national feeling runs high in a Scotch public school. He found he was expected to support the land of his birth; the land of his name rejected him with scorn. This result had its lasting effect. The boy against his inclinations and early teaching had to range himself against what he thought was his own country. Years passed and the man remains the same: he supports the land of his birth, and when the character of the Scots is discussed, though admiring much in silence, he takes a partisan side and brings out all that can be said against the country that years ago rejected him.

A thoughtful and apparently honest man arrives at a conclusion which another equally thoughtful and honest man will inform you is wicked, and nothing but the road to ruin for all those who think similarly. It is not necessary to pursue this subject, but it is mentioned because in those mental states in which distinct abnormality exists the mind of the patient works along the same lines, and false beliefs arise as the result of thought directed irregularly to experiences in the lives of the individuals. An incident may or may not have an abiding effect upon the course of anyone's life. Just as a chance phrase or sentence may influence for a lifetime the opinions of thinking persons, so may an incident be misunderstood and its effects misconstrued owing to lack of the sense of proportion in the mind of the psychopath.

Abnormal mental states arise in persons with a varying personal and family history. Probably the presence of hereditary taint is the most

important factor in the preparedness of anyone to become mentally disturbed or actually insane. Heredity is therefore important, as also are other predisposing factors, but these agents alone do not determine the course which the disability will take. The tendency to insanity exists, and it is the personal experience which goads the intellect along an illogical and unreasonable path. Just as reasoned thought, stimulated originally by an expression or form of words, produced a complicated line of thought which was held through life as an opinion or belief, so in the psychopath an incident may start a complicated system of delusions. The result is, after a space of time, a state of affairs very unlike the original condition. Delusions and hallucinations do not arise accidentally; they have a definite basis, the foundation of which is in the personal experience of the sufferer.

It is the duty of the medical man to analyse the mental processes by which the abnormality has arisen and work back to what may be called the taking-off point. It is not my general experience that these causal factors are always difficult to bring to light. A great step towards removing the difficulty is to gain the complete confidence of the patient, and there is no easier method to attain this end than to have the subject of one's examination constantly intermingling with patients in whom treatment has previously been successful. Some of my most interesting cases have been encountered in dealing with enlisted soldiers. Whether the soldier is more readily made to talk than the civilian may not be easy of proof, but it is probable. In men the cause underlying a psychosis is often reached very quickly, whereas women are more reticent. Not only is this so, but I remember well a case in which a woman of good education deliberately invented what to her appeared to be a very satisfactory collection of dreams and association-tests merely to deceive me so that I might pronounce her recovered, and thus provide her with a suitable opportunity for suicide.

I have said that the determining factor in the mental abnormality may not be far from the surface. It may indeed be so insistent that it is always present in the thoughts of the patient. The after-results of the personal experience may conceal the relationship of the cause and the effect in the patient's mind, and he may describe his symptoms and almost in the same breath give the cause of all his troubles. The patient does not realise the relation of the one to the other, and cannot be expected to do so; and here it is the necessary duty of the practitioner to explain to the patient his symptoms and educate him by showing the interconnection of cause and effect. The means placed at our disposal is through mental analysis. By that I mean an examination which will not only investigate the conscious problems of the patient, but also bring to light the factors of subconscious origin.

When dealing with numbers of men suffering from war neuroses it

was noticeable that as a general rule the functional condition required a great deal more probing to arrive at something satisfying than was necessary in the more organised state of mental inability. And it may be added, paradoxical though it may seem, the functional condition is much more easily treated than the state in which delusions or hallucinations have begun to assert themselves. The mere elucidation of the cause is not enough to effect a cure, and the patient should be taught to follow in their logical sequence all the ideas which he had misinterpreted and misunderstood.

A man was admitted to Maghull Military Hospital showing all the signs of acute depression and considerable confusion. He had been in the trenches for four months in the early part of the war. There had been a mental breakdown nine years previously, in consequence of which he was invalided out of the Navy. He was a married man with three children. In addition to the general signs of depression there were delusions; he said he had only half a body, that the food he took did him no good as it ran out of him. When questioned as to what these ideas meant he explained he had had diarrhoea in the trenches and it had so weakened him he was only "half his old self." The food could not be retained as he thought his rectum had "dropped out, I suppose." The idea that his diarrhoea persisted was incorrect. He had a stool once a day as a matter of fact. Further inquiry elicited the following facts: He was an old naval man living at a seaside town and yet he had not rejoined his old service. He did not try to rejoin: he "wanted nothing more to do with the Navy." He complained he heard a voice saying, "You ought never to have done these things." The patient for a time would say no more about himself. Later he related how he had joined the Navy at fifteen, and had received money regularly for allowing certain practices to take place. The clear relationship of the acts of his youth and the delusions of manhood is evident. The patient had begun to rationalise his bowel sensations and to misinterpret the normal bowel action. After a certain amount of instruction, and the explanation and interpretation of his symptoms, improvement set in. He said to me the voice was no more than his conscience—a correct estimate of the condition.

The hallucination was a very helpful hint that there was more in the case than a superficial examination would show; he thought his food did him no good, that his rectum had dropped out. The man's explanation of his delusions was only a rationalisation, and might have been considered satisfactory. He had passed through four months of strain and stress in France; terrifying experiences disturbing to the emotions would have had time to act upon a man who had previously been insane, but the hallucinations at once pointed the path along which further investigation should go. The patient was suffering from



remorse in an aggravated form. His attitude was one of shame. He was unsocial and avoided others—even his own wife when she visited him. The hallucination was the product of his own thoughts.

Hallucinations do not occur in states of depression at an early stage of the malady; delusions develop earlier. A simple anxiety state with depression may develop into a condition associated with delusions, and this is the more likely to happen if the case is untreated. There are quite enough causal factors associated together in modern warfare to cause a psychosis to develop. The patient, already tormented by a state of anxiety, begins to revert to these gloomy and sordid experiences of his life. Finally, one memory is able to take possession of all his thoughts, and round this subject he will weave his net. The hallucination, "You ought never to have done these things," cannot be said to be in relation with a subconscious thought; quite the reverse. It is in relation with a painfully clear memory. The hallucination as it stands means nothing, and it is only when the man's life episodes are revealed, and the personal matters are sifted, that it can be made intelligible. The presence of hallucinations may be taken as the measure of the intensity of the causal memory image. Just as dreams are helpful in the purely functional case, so hallucinations will surely point to a causal factor of the first importance. The subject of this case made a good recovery, although during his convalescence his wife died somewhat unexpectedly.

The case just recorded may be said to be one in which the personal experience acted as a secondary or indirect agent in the production of the psychosis. In the story which follows the experience was the direct factor, and the mental state arose from looking at the occurrence from an altogether wrong point of view.

The patient was a man æt. 41—a north countryman. He had taken alcohol in the pre-war days rather freely. A reservist, with no previous experience in warfare, he went to France in August, 1914. He was invalided to England with rheumatism in February, 1915, was sent to France a few weeks later, but returned, as the rheumatism recurred in Havre. After some time in an English hospital he was given leave. He remembers getting his papers, but nothing after that.

I did not see the patient until he had been in hospital some weeks. On examination he showed considerable uncertainty of memory, and was obviously depressed, of anxious countenance, his forehead deeply furrowed, the face thin and haggard. He was solitary, avoided his comrades, went for long walks alone, and in short showed all the signs of a man brooding over some occurrence recent or remote.

For three months this man was with me. Any attempt at progress on my part was frustrated by an obstinate silence, or word manipulation.

He was not improving mentally, but after much persuasion the facts of the case were disclosed.

In the winter of 1914 he was sent out one night on a patrol. He was the leading man of six others. Suddenly he felt that he had lost touch with his companions. He was alone, but almost immediately he heard a voice say in English, "Give me your rifle." He could see nothing, but when the order was repeated he bent down and was able to make out against the sky-line the spike of a German officer's helmet. He had little time to make a decision, but holding his rifle in the middle, he drove it upwards at the man in front of him. The officer gave a "dirty laugh, a sarcastic, scoffing laugh." Our patient naturally enough thought he had struck into the lapel of the officer's greatcoat. The next moment the officer fell dead at his feet. He had stabbed him through the floor of the mouth and the bayonet stuck in the skull. The officer carried a sword in one hand, a pistol in the other. The movements and voices of an enemy patrol were heard and our man escaped to his trench. The telling of this story takes time, but the actual occurrence was all enacted in a moment.

Many emotions were stirred in this brief experience. The setting was fitting for a memory which can never leave the soldier. Fear firstly at finding himself isolated, the sudden voice asking for his rifle, the fearful thought that he had missed his man, as evidenced by the scoffing laugh, and lastly, fear of discovery as he attempted to regain his trench.

The soldier from the beginning took an altogether false view of his action. On his return to his trench he only told one man what had happened. He was ashamed of what he had done. He said to me "he would not have minded if it had been a fair fight in the open," and "if he had cursed me I should not have minded, as he would have deserved what he got."

Depression and confusion followed some months later. At night, when in a state between sleeping and waking, he would see the whole incident. The laugh would waken him at night. He would hear the sarcastic laugh also in the daytime. He could not sit in the billiard room of the hospital, as men often laughed in the same sarcastic way when a player failed at a shot. He went away by himself so as to avoid the possibility of having the image recalled by a comrade's laugh.

It is not quite easy to explain the sequence of events in this man's depression. Much would depend upon the mental make-up. He appeared to be a simple, kind-hearted man, but in no way a sentimentalist. He had lived a normal life of boyhood and youth, and joined the Army, as many men do, in order to see the world. On going on the reserve, he had married and worked on the railway.

The event in every-day life which to my mind is perhaps analogous

to this war episode is one connected with association football. In football, when a player within a certain area infringes the law, a penalty kick is given against him. That means virtually a certain goal to the opposing side. In popular football, with the thoughts of the crowd interested more in bets and points than in the play of the game, a cheer goes up at the decision of a penalty kick; but in a truly sporting crowd there is no such demonstration; the feeling created is rather one of resentment against the offending player. The true sportsman would rather not gain a point under such circumstances. Once the decision is given the penalty must be taken, and the player, however much he may have the sporting instinct, must do his best. Reverting to the soldier, he merely did what was his duty. To have done nothing would have meant his own death; he acted under enormous stress. There was at first uncertainty as to the nationality of his opponent, but once he had made a decision on this point he had to act. The common-sense conclusion is that he did right.

The method of treatment adopted was by explanation of his symptoms a comparison of his act with that of the football incident, and a strong appeal to the man's own common sense. The unburdening of himself of the long-kept secret had an immediate effect. The dreams stopped almost at once. Following the first interview after the facts had been obtained, the patient had the best night's rest he had had for months. Ultimately he lost all his depression and was sent home.

I have used this case as it shows what results can be obtained by mental analysis in a patient in whom there is no connection with sexual matters. It is unfortunate that to many mental analysis should have reference to this subject of necessity. Many cases, when analysed, no doubt, have to do with sexual things, but in very many the reverse is found.

Finally, I would record another example of the close connection between memory of an action in boyhood and the fully developed delusion in manhood. The patient was a soldier, æt. 24. When he came under notice he was acutely depressed and was under the impression that people were accusing him of being a murderer.

His father was an alcoholic, and he himself had drunk very considerably. He has never been able to stand the sight of blood. When twenty-two he was sick when he saw an ox killed. He went to France in August, 1914, and felt sick and faint when he saw a man blown off a horse and killed. He was returned to England within a fortnight with rheumatism. In March of the following year he went to the Dardanelles, and there worked with his battery for four months. He became confused on Gallipoli, and wandered about aimlessly, so that he was sent home. His memory of the events of the voyage home is very incomplete.

When examined he was highly emotional, wept whenever addressed, and went on his knees praying for forgiveness of his sins.

A word analysis was tried, and it gave some interesting reactions. Many of the tests are omitted, and a few selected ones only given.

Tired—very, thinking how he has always to be pushed on to work.

Forget—never, the lessons he has had, all his past misdeeds.

Breath—holy, the breath given to us all is given by God.

Fire—hell, hopes to keep out of hell fire.

Mouth—river, after a considerable interval “no fastings.” The need of fasting on account of his wickedness.

Happy—very, he should like to be very happy.

Broken—often, refers to his promises.

Hope—always, to do his duty and live another life.

End—never, world without end.

Death—an interval of twenty-four seconds, and then, “Death did you say?” Sting, later he said his first thought was “Beautiful,” then “Envy,” then “Happy” (these all refer to a sister’s death).

It will be seen at once how the idea of self-reproach and unworthiness is running through many of the associated words. Some replies indicate his religion, and the tendency to seek relief from his present oppressive thoughts by an appeal through his spiritual beliefs. He shows in the words “end—never” that his outlook must indeed be terrible if his present misery is to last everlastingly; or possibly he means that his fate is unending as his sins are unforgiveable. Lastly, the reaction-time for the stimulus word “death” produces thoughts but no spoken word, except after a long interval. “Death” and “sting” are a normal reaction, and had the reaction-time not been taken the associated word would have caused no criticism. The man admitted, however, under pressure he had thought of three words and rejected each, as he did not want to talk about them.

He heard people calling him a murderer, and he said he was the wickedest man on earth. In addition, he said he often thought of his home, of his sister who died, and he had heard her say to him at night, “I am happy.”

His youth had been a disturbed one. His parents were not of the same religion, and though he had embraced his mother’s religion, his father often quarrelled with him about it. His sexual life was an unhealthy one. Living in the same room with two sisters, he had had incestuous relations with one and had attempted similar things with the other. His sister died of lung disease at a time when these practices had not ceased. She was quite young. He thinks that by these practices he had so weakened her that lung disease overtook her. He used a forcible expression, which I cannot repeat here, of his belief in this subject. He was an ignorant boy, poorly educated, and running



wild with little control as a youth. He had read, however, in pamphlets of the dangers of sexual matters when carried to excess, especially in the young and immature. He applies this theory to his young sister, and blames himself for her death. The word "beautiful" refers to the dead girl lying surrounded by flowers preparatory to burial. Happy—he is expressing the hope that she is happy in Heaven, and the hallucination, "I am happy," is nothing more than a wish fulfilment. Envy—how he envies his sister in the pure state of the life hereafter as compared to his miserable, sordid life on earth. Self-accusatory thoughts are very usual in depression, and the word "murderer" is only an exaggerated impression of his own view of the result of his own wrong action. Unfortunately I lost sight of this patient, but when I last heard of him the opinion prevailed that he was not likely to do well. His psychosis, however, is interesting, and shows the relationship of the human side of the patient's life and the later development of the delusion and hallucinations from which he suffered.

Without such a personal history nothing in these cases could be understood, and the opportunities for treatment would resolve themselves into improved hygienic conditions and rest.

Sir GEORGE SAVAGE said the subject now under discussion had interested him for about half a century. He would have preferred to see the paper bearing the title he himself used many years ago, "Morbid Mental Growths." Taking it for granted that in nearly all these cases there was a starting-point—often of a physical or psychical nature—when one came to consider the growth of delusions it led one back, as an Irishman might say, to the present time, because psychic analysis and that kind of procedure led one back to the morbid mental growth. The development of former ideas from the subconscious was a very old subject of study. It had been generally recognised that nearly all delusions had a starting-point, and the influence the starting-point had upon any subconscious area was only that of moving it one step backwards. In treating of this subject he had said there were morbid mental growths which were simply inconvenient; probably most had similar morbid ideas—some obsession which did not really interfere—but all had seen individuals with one great dominant idea which influenced their whole life and yet destroyed nothing. These were innocent morbid mental growths. But there was another form of delusion—morbid growth it might also be called—which not only interfered with utility but probably with mental action, yet was not destructive. In the third group, however, there was destruction, so that the morbid mental growth seemed not only to invade but to destroy faculties. The manifestations varied according to whether there was hypochondriasis on the one hand or delusional insanity on the other. The hypochondriacal person, who was merely morbidly self-conscious, might yet not be mentally defective; but the person with delusions of persecution probably had a form of disorder which was very destructive. Most of the members knew, too, of the intermediate type, in which an individual had delusions growing out of his hallucinations, and yet such individual continued at his work. Thirty-five years ago, a gentleman who had occasionally attended the Association's meetings was acting as dispenser to a doctor in the south of London. The doctor consulted me about him, and I said to the doctor, "Good gracious, he ought to be locked up!" He had what was called "clair audience," "clairvoyance," and occultism generally. That individual had not been in an asylum, but had been treating the poorer residents of a suburb of London all this time. Here was a morbid mental growth which did not interfere with the man's usefulness. Deafness had frequently been associated with forms of disorder. He believed that one lady novelist was so deaf that she never

heard anybody contradict her, and hence she had very exalted ideas of her own power. It was, however, much more common for those who were deaf to have the impression that other people were talking about them.

Dr. HUBERT BOND, in obeying the President's invitation, said he did not feel he could add anything on the lines taken by the first speaker. During the reading of the paper, and while Dr. Stewart was speaking, he was thinking of how many of those present missed their revered *confrère* and former President, because of the magnificent opportunity afforded by such a paper as this for his criticisms and remarks on the relation between the branches of their work. As to the paper, he had a sense of very great encouragement as the result of the treatment detailed. There must be several men of standing in medicine present, and he assumed that they, like him, were taught the futility, if not the inadvisability, of attempting to reason with a delusional patient; that in a case of delusions and hallucinations the mind was not deluded because of hallucinations, but that both symptoms were the outcome of the morbid mental state. Was not that the case because the physician had no means of getting at the right topics of conversation when approaching the patient? And was not the lesson which had been learned, not only from Dr. McDowall's vivid description of the cases but also from other writings—some from war cases—that the profession now had before it the modern means? He was aware that some were inclined to scoffingly assert that there was in this nothing new, and that it was what had been taught when they were younger, but he did not feel it was so. The results of the last few years' experience had certainly taught him that they had now at hand modern means of attacking patients on the right lines and instilling reason into some of the most—apparently—hopeless cases, and in that way promoting their recovery. It was that feeling of encouragement which he wished to emphasise.

Dr. R. H. STEEN desired to thank Dr. McDowall for his paper. He, the speaker, wished to lay emphasis on the idea that delusions were often wish-fulfillments, and to ask if Dr. McDowall had noticed this fact in any of his cases. Of course, distortion of the wish existed in the case of delusions as in the case of dreams. A recent case which made a great impression on him he would relate, altering, of course, the names of the persons: A patient, Miss Smith, came into the institution, and he made a long and careful history of the case. It appeared that, years previously, she had known a Mr. Jones, a clergyman, and she considered that he was paying her special attention. But it could not be gleaned what form the advances had taken. She had once shaken hands with him, but had seldom conversed with him. She said that in his sermons he made remarks concerning her. A few months later he, the speaker, was surprised to learn that she had asked all to call her by the name "Mrs. Smith Jones," to emphasise what she stated as a fact—that she was now married to Mr. Jones. He related that as an instance of how the delusion came to be a definite fulfilment of a wish.

Dr. CARSWELL said he regarded it as a matter for great satisfaction that the younger men were devoting themselves to fresh clinical studies. He was sure the outstanding need of the specialty at the present time was for the men who had an opportunity for seeing a large number of cases to make fresh clinical studies, with minds free from the preconceptions of the past. By habit he had always felt himself drawn intensely to the progressive side, yet he had a feeling that, after exploring along the lines stated in this paper, they would come back to most of the old views; that they would not derive the satisfaction at present apparently promised by their theories, which were based on the conception of a conscious and subconscious mind. Nevertheless, good was bound to come of such studies as those set out in the paper. Of course, all the phenomena manifested in the cases related by Dr. McDowall could be explained without the nomenclature of the newer psychological point of view. They had all been familiar, because it was true to experience, with the fact that all delusional ideas had their origin in some experience. There was nothing which came to any man in the form of a fresh idea that had not had a basis in a previous experience of some sort; and the lunatic, or the person who became afflicted with a morbid idea, was simply basing his morbid idea on that past experience. To unearth that experience, to explain the road by which the patient had arrived at his false idea, was a very valuable thing to do, and he hoped it had been the usual practice, though he gleaned from the remarks of Dr. Bond that it had been avoided. No one could run a hospital for the

treatment of early mental conditions, before they arrived at the asylum stage, without feeling forced to adopt the method of quietly, calmly, and persistently seeking to explain to the patients the origin of their morbid ideas, and to surround them in the hospital arrangements with the pervading idea that they were suffering from an ailment, not a delusion in the sense of being a baseless alienation of the mind; that it was a disorder arising from some experience, taking on special colouring by some morbid emotional tone, and the whole associations connected with it being such as could be suitably handled by hospital methods, and by the educative methods so successfully adopted by the psycho-analysts.

Dr. J. G. SOUTAR said he thought one of the most interesting features of Dr. McDowall's paper was that he did not trouble his hearers very much with the sub-conscious, and he did not deal at all with what was termed "psycho-analysis"; rather he found a common-sense explanation of the growth of delusions in the really conscious life of the patient; his analysis was the ordinary simple investigation into the patient's life-history. In that way he had been able to bring out not really the genesis of delusion, but he had shown why it was that delusions took a particular direction and form. The author had not carried members back to what they really wanted to know—why a man who had hitherto been acting in what was termed the ordinary sound way, on the lines along which all their minds went, should, either suddenly or gradually, take on a morbid line of action, of which delusion was but one manifestation. The recognition of the pre-delusional stage—of that condition of mind in which delusions would be apt to flourish—was most important, for then it was that the patient was most amenable to treatment. He looked upon the delusions and the hallucinations as the later and obvious manifestations of an already unsound mind. The delusions did not arise only as wish-fulfilments. He thought many of them arose from the patient's past experiences, failures which had not given any trouble through a long period of life, but for some reason, some departure from health, were keenly remembered, and there were crowded around them appropriate emotional states. Dr. McDowall said delusions preceded hallucinations, though he did not think it was laid down as a general statement. He (the speaker) thought hallucinations often preceded delusions, and the latter took their form from the hallucinations. A patient heard voices or had perception of unpleasant odours—in fact, there were general sensory hallucinations. Then there came a period of acute depression, followed by a period of questioning as to why he was singled out for persecution. Then the other emotional state, one of exaltation, followed, along with the definite delusion that the person was an individual of great importance, otherwise he would not be so persecuted. With regard to the method of dealing with delusions, the re-educating of a patient was, he considered, of the greatest possible value. Dr. Bond referred to the old teaching that it was not desirable to argue with a delusional case. That was true were arguing in question. But re-education was a different matter, as that enabled a patient to obtain an insight into his or her condition, and was of the greatest value. If one could succeed, even to some extent, in modifying the baneful influence of a delusion upon a patient, one thereby did a great deal towards getting that person into a sound state of health, because a delusion was irritating and worrying, and was consequently affecting the whole health of the patient. Even simple worry produced a deleterious effect upon an ordinary person, and if this worry could by some means be alleviated something was thereby being done to break the vicious circle which was keeping up the ill-health of the patient. Dr. McDowall had put his cases in the most vivid way, and he (the speaker) would like to add one to the list of the cases which had to-day been related. A lady, the only child of people who were in a very good position, but were in straightened circumstances, when 22 years of age married a very old man, a widower with no children, who, for his property's sake, was very anxious to have a child. She married in face of her parents' strong opposition. In course of time both her father and mother died, as did also her husband, and there was no child. When between 50 and 60 years of age the lady herself broke down, and her delusion now was that she had got her father, her mother, and her husband in her womb. The association was easy to see, but the important question was, Why did that particular type of delusion arise? Indeed, why did she become deluded at all? What was the state of mind into which she had got? It was

true that the ordinary changes were taking place in her womb, but beyond that there was no reason for it. Here there was no question of wish-fulfilment, but a recognition of the painful episodes of her life. There had been no reconciliation between herself and her parents, there had been failure to produce a child, and she had crowded her failure into her womb. Past experience was not wish-fulfilment, and almost any experience of the human mind was capable of being perverted into a delusional condition.

Capt. PRIDEAUX suggested that probably the treatment in the sense Dr. Bond gave it was not really what was used by Dr. McDowall in the treatment of his cases; it was really more the use of emotional processes. Persuasion was based upon the use of these, and he thought that if one went back to the genesis of delusions it was found in the derangement of the patient's emotional life. That emotion could produce dissociation in two ways—either suddenly, as in sudden fear, or gradually as a result of a prolonged mental conflict. To his mind the genesis of delusions seemed to be in the emotional sphere by subsequent dissociation, and for that reason emotional processes may form part of the treatment adopted. For instance, a state of fear was instantly changed by a state of anger; as soon as the emotional state was changed there was set up a different arrangement of mental processes: the association of mental processes was governed by the emotional state of the person. Some of these delusions seemed to arise when a man was in a state of dissociation already. He had one case in which the patient, whilst undergoing treatment for shell-shock in a hospital in France, developed the hallucination that he saw his brother walking about with his head under his arm. This originated from a letter written to him by his mother describing a similar hallucination she had had during a Zeppelin raid. After the origin of it had been cleared up he got perfectly well.

Dr. McDOWALL, in reply, said he understood Dr. Steen to mean that many delusions were wish-fulfilments. (Dr. Steen: Yes.) In regard to the case related by Dr. Soutar, he (Dr. McDowall) thought that could be made out to be a wish-fulfilment. Dr. Soutar asked what was the soil which would best grow delusions. That was the great difficulty in the whole medical world. We did not yet know that. His only idea in the paper was to give some examples of delusions and to point out that they were quite capable of treatment along certain lines. Dr. Carswell had referred to nomenclature, but he (Dr. McDowall) thought he had been very discreet in avoiding many of the words in use at the present day. At the same time they were all very useful words. His own view was that delusions did come as a result of previous experience. With regard to the subconscious mind, it was not always necessary to suppose that in insanity the subconscious mind should of necessity contain the determining fact of the psychosis. In the first case he referred to he tried to point out that the real disturbing element was far from being subconscious; indeed, it was very much on the surface. But the subconscious mind was, undoubtedly, a very important factor, and his view was that it had more to do with functional cases than had the true psychosis. Dr. Soutar had asked about hallucinations. The sentence he (Dr. McDowall) read about that was: "Hallucinations do not occur in states of depression at an early stage in the malady; in depressions delusions develop earlier." He believed that to be true. In maniacal states hallucinations occurred before anything else. But in true depression, simple depression came first, delusions followed and hallucinations came later. That was his feeling, though he might be wrong. With regard to the case referred to by Capt. Prideaux, the idea of the other boy who developed hallucinations regarding his brother came merely as a suggestion, and a man suffering from functional disorders such as he was was the very kind of case to be influenced by suggestion. No doubt he was already being treated by means of suggestion by someone else.

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*Some Present-day Problems Connected with the Administration of Asylums.* By BEDFORD PIERCE, M.D., F.R.C.P.Lond., Medical Superintendent, The Retreat, York. A contribution to a discussion on Administration of Asylums at the Spring Meeting of the Northern and Midland Division.

IN many respects the difficulties of administration are greater in hospitals and private institutions than in public asylums maintained out of the rates. The financial problems raised by the reduction of hours and the increase in salaries, as well as the greater cost of all commodities, are very serious when there is little prospect of increasing the income to meet the increasing expenditure. What will happen if the present tendency continues no one can foresee, but it seems quite clear that the middle classes will soon be unable to bear additional burdens. Already many patients with limited income cannot possibly pay increased charges, and it would be cruel to discharge, for financial reasons, aged patients who have been under care for years, and have no other home than the asylum in which they live.

Serious as the financial problem is, there are other disturbing questions of even greater moment. There is, I fear, slowly developing a want of harmony with the staff and the management, and a deplorable tendency to ignore the welfare of the patients. In the recent demands of the Asylum Workers' Union I could see no trace of any concern for the patients. There was no sign of any proper nursing spirit; all the staff were counted equal in the Union, and demands were made for reduction of hours quite irrespective of the duties undertaken. I only judge from the printed circular, and I have not come into personal contact with any of the leaders of this movement, and possibly I may misjudge them to some extent. Still, there are many indications that the well-being of the patients is not the primary concern of members of the Union.

But, as was remarked at one of the special meetings of the Medico-Psychological Association in London, we physicians have also been to blame to some extent, and we must not be surprised that the nursing staff do not readily accept our point of view. Long before the war the pay and the conditions of service of the mental nurse left much to be desired. I have always felt that men or women who devote their lives to nursing the insane deserved much greater recognition than has been given. The work, as we know well, is often very arduous, and brings little reward beyond the satisfaction of doing difficult work well, the pay has been miserably poor, and there have been few signs of appreciation from patients, their friends or from managing committees. When we think of the daily routine in many wards, the discouraging nature of the

work, and the unpleasant duties that have to be performed day after day and week after week, we admit that the conditions of service ought to be good and the remuneration liberal. Yet we, who knew all this, did not, I fear, press upon our committees in season and out of season the urgent necessity for their giving attention to these aspects of the question.

The situation seems to require some clear thinking, or I fear the work of the Association to raise the level of mental nursing will be undone. Hitherto the nurse who has obtained the certificate of the Association has only received a small increase of salary, with the result that in many asylums only a small proportion of the staff are trained nurses. The training itself has not always been thorough, so that the certificated nurse has frequently not been worth promotion to senior posts. The suggestion I would make is that the Association renews its efforts to train nurses well, and also that every effort be made to render the position of the certificated nurse much better than those not so trained. The man or woman who takes up this vocation should find that mental nursing is a career which brings not merely adequate remuneration, but also a social *status* quite removed from that of the ward-maid or labourer.

I have always tried to teach our nurses at the Retreat that they were taking up a profession akin to that of the physician, and I have read to them extracts from the Hippocratic oath referring to the sacred nature of their responsibilities towards their patients.

Thus, on the one hand, I would urge a far greater improvement in the conditions of service of the trained, experienced nurse than has already been obtained, and on the other I should demand much greater devotion to the work than seems to be compatible with the trade union spirit.

I am quite certain that the more carefully we personally train our nurses, and the more we can infuse a proper professional spirit, the less we shall be troubled with disaffection and discontent. But at the same time, the more we bear in mind the conditions under which our nurses work and the more we understand and sympathise with them in the discharge of their truly arduous duties, the less we shall be satisfied with things as they have been in respect to hours, pay, and conditions of service generally.

The practical difficulty is what to do with the many excellent persons in our employ whose education and general qualities do not permit them to reach a sufficiently high standard. I presume, for some years at least, we shall have two classes—the partially trained and the trained certificated nurse. At the Retreat we have begun to pay certificated male nurses £20 per annum more than attendants, and it is intended this amount shall be increased. I look upon this only as a start, but

it is a step in the right direction. On the other hand, it will be desirable to arrange that special qualifications in the senior attendants should receive recognition.

These proposals are only of value if the training the nurses receive is adequate.

There seems to be room for considerable improvement in the present system of training, and the regulations of the Association require amendment.

Some years ago, when I was examiner for the Certificate, it was clearly evident that many nurses who presented themselves for examination were practically illiterate, whilst there was reason for concluding the training they received was poor. The number of lectures allowed by the regulations is far too few. There is no proper provision for demonstrations and instruction in practical nursing. Invalid cooking should be taught to all women nurses, and opportunities given for instruction in massage. The class examinations should be compulsory, and only those who succeed reasonably well should receive advances in salary. In this way the illiterate who fail to educate themselves would gradually be eliminated.

Lastly, it has been the practice at the Retreat for many years only to take nurses who sign an agreement to go through a course of training for four years. I consider this period for training necessary, and it corresponds with the years of apprenticeship required in many trades. Nurses learning their profession should receive only a comparatively small initial salary, which should rise steeply as they progress, and when qualified they should command, as I have already said, a salary proportionate to the responsibility of their calling.

If it be found impossible to secure men and women to train on lines such as these, then I suppose others must be engaged, but these would not be trained, would not attend classes, and should never reach responsible posts. They would be attendants and not nurses. Their initial salary might be higher, but the advances would be more gradual, and the final pay much less. This view of the matter is similar to that in many trades: the man who begins as a labourer gets more pay than an apprentice, but remains all his life in an inferior position.

It seems to me that the Medico-Psychological Association can do much to help the nursing profession, and greatly benefit patients if it steadily perseveres in its policy of training mental nurses, and sees that the training given is really effective. This will inevitably result in improved *status* and better remuneration for the nursing staff.

It may be interesting to give particulars of the introduction at the Retreat of Departmental Councils, on the lines of Whitley Councils now so general in industrial concerns.

Three departmental councils have already been started—(1) For male

nurses; (2) for female nurses; (3) for the outside staff, including artisans and engineers.

In each of these the staff concerned elect five or six representatives, care being taken that all classes in the department are represented. The management is represented by one or two members of the Committee, the responsible officers of the department affected and myself.

Each Council appoints a clerk, who keeps the minutes, and the minutes are submitted each month to the Committee of Management. The Councils meet monthly.

So far the meetings have been useful, the discussions have been frank, and the impression on my mind is that they will promote a better understanding. The attitude of all the Councils is thoroughly loyal to the institution. No doubt in time questions will be raised which the Committee may decline to take up, but there is a reasonable hope that the interchange of opinion will lessen the risk of dissatisfaction and discontent.

The relations between the management and the staff at the Retreat have always been harmonious—indeed, it has been a sort of family party; but I encouraged the establishment of these Councils in view of the tendency of the times, and if possible to anticipate the difficulties which I knew existed elsewhere.

One question raised may be alluded to. It was asked whether the Committee would object to members of the staff joining a trades union. They received the formal reply that the Committee raised no objection whatever, but they wished it to be understood that they would not willingly retain on the staff any persons capable of leaving, and so neglecting their patients, without giving adequate notice. Other subjects referred to at these Councils have been the difficulty of reducing hours when short-handed; the proposed new time-table giving fifty-three hours a week and a varying period of about three hours weekly to games and entertainment of patients; the stokers' hours of fifty-six per week—three shifts of eight hours each; the cultivation of games amongst the nurses; holidays for gardeners, etc. All these subjects are discussed, but the final decision rests, as heretofore, with the Committee of Management.

I cannot but think the old days of autocratic management are over, and though some who think a beneficent autocracy is the best form of government may lament the change, we can nevertheless look forward without dismay to the new era of democratic control if the proletariat recognises its responsibilities. The Works Councils are, I consider, useful as a means of introducing the spirit of mutual understanding and co-operation without which no institution can be successfully managed.



### Clinical Notes and Cases.

*A Group of Fits.* By ALAN McDougall, M.D., Director of the David Lewis Epileptic Colony.

THE patient was a girl, æt. 13, who is stated to have been epileptic from the age of five. The group comprised 3,231 discrete fits, and occupied 17 days: 2,258 of these fits occurred in the course of 6 consecutive days (averaging 1 every 3·8 minutes), and of these 1,694 occurred in the course of 4 consecutive days (averaging 1 every 3·4 minutes). On February 21st there were 443 fits; on February 22nd there were 437; on February 23rd there were 41; on February 24th there were 3; on February 25th the girl was up, dressed and going about.

Here is her daily record of fits for the month of February:

#### *Fits during February, 1919.*

Day of the month.	Number of fits.	Day of the month.	Number of fits.
1 . . .	17	15 . . .	195
2 . . .	11	16 . . .	160
3 . . .	6	17 . . .	236
4 . . .	8	18 . . .	323
5 . . .	13	19 . . .	442
6 . . .	13	20 . . .	372
7 . . .	50	21 . . .	443
8 . . .	187	22 . . .	437
9 . . .	121	23 . . .	41
10 . . .	33	24 . . .	3
11 . . .	17	25 . . .	4
12 . . .	14	26 . . .	6
13 . . .	68	27 . . .	None.
14 . . .	87	28 . . .	2

Born on August 20th, 1905, the patient was admitted to the Colony in January, 1914. To the end of February, 1919, our record of her fits is 12,363 (practically 200 a month). This does not include fits that she may have had during visits to her home. She is lively, active, pretty, a little coquettish, and, though a poor learner in school, fully interested in her neighbours, her hair ribbons, and her pursuits. In physical appearance, development, and manner she might pass for a child of ten.

Clinically, the fits in this February series were mild major epileptic attacks. The eyes and the head were twisted to the left; there was a

tonic stage followed by a clonic. There was little cyanosis. There was no tendency to bedsores. There is no record of the temperature at any time reaching 100° F. There was incontinence of urine.

On February 7th, the first day of the group, a 15-gr. dose of chloral was given. No noticed benefit resulting, the dose was not repeated. Except for that one dose no drug was given while the group lasted. Till the fourteenth day of the group Benger's food was given by the mouth; on the three following days feeding was rectal, as the patient opposed feeding by the mouth. Judging by the eye, she did not lose weight during the illness.

To those who were having the trouble of the case and writing down the time of onset of each fit to the nearest minute, it sometimes seemed that fits were suspended while the patient was being examined and began again as soon as the examination was over; at other times it seemed that the attacks ceased if the patient were left alone in the room, the observer being out of sight but within hearing. In the first days of convalescence the child, though as lively as ever, would not talk, but made somewhat ostentatiously the sounds of a baby that has still no vocabulary. Wherefore the fiat went forth on the Thursday morning that unless meanwhile she took to talking properly there would be no penny for her on the Saturday. That may or may not be the reason why she recovered normal speech on the Friday.

What is the diagnosis?

The answer seems to be: The fits were epileptic, the condition was hysteria.

For I take it that when the subconscious mind has ousted the conscious mind and has usurped sole command, the condition is hysteria. Let the fits clinically be what they will, if they are of conscious origin the condition is malingering; if they are of subconscious origin the condition is hysteria; and if of unconscious origin the condition is epilepsy.

For the most important of all purposes, that of treatment, the view that the physician takes of the origin of a group of fits is of more than philosophical interest. For it influences the treatment and consequently the result. Among those who had charge of the case now under consideration the opinion was general that a stimulating slap in the interval between two fits (by startling the conscious mind back to duty) would have cut short the series. The experiment was not made, because in the presence of good nursing and the absence of drugs the prognosis seemed to be quite good, and the introducing of a risk seemed only doubtfully justifiable.

In certain patients at the Colony we have seemingly been able to prevent the recurrence of serial trouble by giving the patient good cause to wish series not to recur. For instance, one young woman who for

years had been having several isolated fits a month began to have groups of four or five hundred. Clinically each fit in a series seemed similar to the fairly severe isolated major fits that were usual in her at other times. There was incontinence of urine and of fæces. Accumulation of mucus in the air-passages with cyanosis and difficult breathing gave the series a grave aspect. But on the patient being told that because of these series it would be necessary to discharge her from the Colony, she replied that she would have no more of them. She kept her promise. Isolated epileptic attacks continued to occur, but there were no more series.

Markedly in epilepsy *post hoc* is not always *propter hoc*; we see sudden improvement that we are unable to ascribe to changed treatment. But year by year the feeling grows stronger in me that the frequency of fits that are called epileptic may sometimes be diminished by treatment that is generally called anti-hysterical, and that it is not necessary in every case of serial epilepsy to give dangerous drugs. In other cases such drugs may give the patient his best chance of not dying. What we for practical purposes want to know is, which series are in themselves dangerous to life, and which are not. Is there any sign that will enable us to arrive at a decision?

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## Part II.—Reviews.

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*Papers on Psycho-analysis.* By ERNEST JONES, M.D., M.R.C.P.Lond.  
Second edition, revised and enlarged. Pp. 715. London: Baillière,  
Tindall & Cox.

Not so long ago, when the Darwinian theory was mentioned to many a man of superficial learning he would dismiss it with a contemptuous look and the statement "Oh, that means that man is descended from monkeys," and so far as he was concerned that ended the matter. At the present time when psycho-analysis is spoken of even in scientific circles a similar scorn may be shown, ending in the phrase that psycho-analysis puts everything down to sex. For such people Freud's psychology means the psychology of sex alone, and they are too high-minded to have anything to do with it. They know nothing of Freud's views regarding determinism, the affective processes, the displacement of affect, and the dynamic nature of mental processes in general.

The subject of conflict with its frequent termination in repression, the nature of unconscious processes and their manifestation in disguised forms are unknown territories to these people. Then there are dreams, the psychology of wit, the psychology of every-day life, etc. This list to be complete would need considerable extension, but enough has perhaps been said to indicate that Freud's psychology cannot be limited to the catchword "sex."

It is not the purpose of this review, however, to hold a brief for

psycho-analysis; it is rather the intention to indicate that it is unfair to judge of anything without studying it, and secondly, to suggest that ignorance is unseemly in anyone professing to be a specialist in diseases of the mind. It is not so surprising after all to find that numbers of the laity have more than a smattering of knowledge on these matters considering the numerous publications for general readers, and these same folk may ask for an opinion which cannot be given without some knowledge of the subject under discussion.

Most of Freud's writings are in German, and to the man unacquainted with this tongue such literature is a closed book. Moreover, Freud to the expert in German is, I am told, not easy to follow. It is therefore fortunate that we have in Dr. Ernest Jones one who is able to write clear and precise English. He is not merely a translator of the words, but an expositor of the ideas of Freud. In addition there is the satisfactory feeling that it is the orthodox Freud one is reading. In these days, when many of the original band are leaving their master to set up conventicles of their own, it is refreshing to find one who still holds the old faith. Dr. Jones will have nothing to do with the schools of Jung, Adler, and the other seceders. Dr. Jones also has contributed some original work on Freudian lines, and papers embodying this are included in the present volume.

It is impossible to review in detail a book of this kind. It is much larger than the first edition, which was published in 1912. One chapter of the original twenty has been omitted, and twenty-one new ones have been added. It consists of a series of papers and lectures given at different times. Naturally there is some repetition, but it is surprising how small this is in amount, and even then it assists in understanding the subject and never becomes tiresome. When another edition is called for it is hoped that Dr. Jones will elaborate Freud's views on wit and its relation to the unconscious. This matter is dealt with very briefly in the present volume. It is realised, however, that it is impossible for the author to deal with everything and keep the book down to a moderate size. Among many excellent papers it is not easy to pick out one for special praise, but Chapter VII, dealing with the theory of symbolism, is certainly a most interesting and valuable one. Taking, then, the book as a whole, it can be heartily commended to the readers of this Journal. Everyone interested in the psychology of Freud must possess a copy. The value of the book is enhanced by the glossary which is appended.

R. H. STEEN.

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*Criminology.* By MAURICE PARMELEE, Ph.D., Professor of Sociology in the University of Missouri. New York: Macmillan, 1918. Pp. 522. Price \$2.

Prof. Parmelee is known as the author of an esteemed work on *The Principles of Anthropology and Sociology in their Relations to Criminal Procedure*. It was published ten years ago, and since then, as the author tells us, the subject has been transformed. He here presents an entirely new work, a comprehensive but compact text-book of the whole subject of criminology. There are some among us who deny

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that criminology has any right to exist. Everything brought forward under that head, they explain, could be included under some other head. It is quite true. At least a dozen different sciences contribute to make up what is called "criminology." That is precisely the justification of criminology in bringing together all that bears on the nature of crime and the treatment of the criminal. Certainly this has been a favourite field for *doctrinaires* and dogmatists, each worshipping his own particular fetiche. Dr. Parmelee gives them but short shrift; for the most part he ignores them. We are conscious throughout of a calm and judicial mind, always able to see the various sides of a question, always carefully weighing and balancing before reaching the finally measured result.

What is crime? Primitively, crime is a violation of custom, magic and religion, as well as moral ideas, later coming in to reinforce custom. At the present time a crime is, in Dr. Parmelee's view, best defined as "an act forbidden and punished by the law, which is almost always immoral according to the prevailing ethical standard, which is usually harmful to society, which it is ordinarily feasible to repress by penal measures, and whose repression is necessary or is supposed to be necessary to the preservation of the existing social order." There is consequently, as is indeed generally recognised, no hard and fast line between criminals and non-criminals. Legal and moral conventions, which are always changing, determine what acts are criminal, though—and this is sometimes overlooked—there are several types of persons who are always peculiarly prone to violate these conventions, whatever they may be. So that the criminal class at any time is determined in part by what acts are criminal, and in probably larger part by traits more or less universally characteristic of this class. But the fundamental factors in the determination of criminal conduct, as of every other kind of conduct, are the elementary traits of human nature. No one of these traits alone causes such conduct, so that it is inaccurate to speak of an instinctive criminal, but any instinct may under certain conditions lead to crime. There are, therefore, no peculiar crime factors in human nature. Every human being has in him the making of a criminal. No person is born criminal in the sense that he is predestined to crime at birth, though it is convenient to speak of several types of persons born with abnormal traits as congenitally criminal. Like every other kind of conduct, criminal conduct is the outcome of these internal factors of behaviour with the external factors of environment. These principles thus laid down by Dr. Parmelee at the outset are elementary and simple, but the failure to understand them has led to many unnecessary disputes.

After the preliminary discussion of the nature and evolution of crime, the main part of the book falls into four parts: First, the discussion of the criminogenic factors in the environment—climatic, seasonal, demographic, economic, and civilisational; then the organic basis in traits and types, with criminal aments and psychopathic criminals, as well as chapters on juvenile and feminine criminality; then criminal jurisprudence with the judicial and police functions; and a final part discussing in a large and liberal spirit social readjustment and the prevention of crime. A selected bibliography of ten pages brings to an end a work which for

its purpose, as a text-book of criminology, probably deserves to supersede the existing books, although on the narrower ground of the nature and treatment of the criminal it cannot of course compete with the masterly work on *The Individual Delinquent* by Healy, whose experience and success in this field can at the present time scarcely be equalled.

In his classification of criminals, Dr. Parmelee characteristically avoids the excesses alike of those who carry simplicity to an impossible extreme in the ordinary two-fold grouping and those who indulge in fine-spun elaborations which cannot be applied in practice. He recognises five groups: (1) The criminal ament or feeble-minded criminal; (2) the psychopathic criminal; (3) the professional criminal; (4) the occasional criminal—(a) accidental, (b) by passion; (5) the evolutive criminal (political). He reaches this statement after a detailed criticism of the earlier classifications. Lombroso's classification, as we should expect, he discards, and points out that the "born criminal" is not a simple group but really appears under several headings, chiefly in his own first and second groups. While, however, Dr. Parmelee sets forth in order Lombroso's "egregious errors" with his usual fair-mindedness, he has no mercy for those guilty of the ignorant and prejudiced abuse of Lombroso which was at one time prevalent. Thus he shows an unwonted vivacity in dealing in a special appendix with the "gross," "inexcusable" and "grotesque" misrepresentations of Dr. Goring, though, he points out, that self-contradictory writer in his extreme emphasis on "criminal diathesis" was himself "more Lombrosian than Lombroso."

It is impossible to mention all the points of interest in Dr. Parmelee's work. We do not expect new facts in a text-book, and we do not here find them. But every one of the thirty chapters is rich with thought and suggestion, not the less so because some of them may seem to the conservative English mind a little far ahead. In criminal procedure the author proposes a number of simplifications: he approves the modern approximation of the English procedure of accusation and the French procedure of investigation, for while the latter, based on the protection of society, is a higher and more advanced conception, in practice it tends to violate individual rights, and needs to be corrected by features belonging to the English procedure. With regard to medical jurisprudence the author is averse to leaving any decision to lawyers and jurors who know nothing of the questions involved. The decision of medical questions must be left entirely to the medico-legal expert, whose position must be impartial like that of a judge. The foundation should be an organised system of medical jurisprudence which could supply a medico-legal court of appeal, since the system which permits ordinary physicians with no special training to act as medico-legal experts has been proved a failure. One result of this reform would be the abolition of the coroner's office and the gradual elimination of the jury from law-courts. Dr. Parmelee also advocates a Public Defender to supplement the Public Prosecutor, and free civil justice. He thinks the idea of punishment can scarcely be altogether eliminated, but fully accepts the modern principle of individualisation in dealing with criminals.

HAVELOCK ELLIS.

*A Plea for the Insane.* By L. A. WEATHERLY, M.D. Pp. 238.  
London: Grant Richards, Ltd., 1918.

This volume consists of a vigorous plea for the reform of the existing conditions in respect to the care and treatment of the insane. The wide experience which Dr. Weatherly has had of the practical applications of the Lunacy Law, which is now generally recognised as quite inadequate to meet the needs of the subjects of mental disorder, has thoroughly fitted him for the task which he has undertaken. The book is designed in the main for the enlightenment of the general public and the general practitioner, as the writer feels that the demand for drastic reform by the public themselves will do much to accelerate the much-needed changes. The first ten chapters are mainly devoted to criticism of the Lunacy Act and those who are responsible for its administration, and incidentally this section furnishes facts of considerable service to the general practitioner, who is often at a loss to obtain information as to the legal complexities associated with lunacy administration. Many points are raised. Legislation, public officials, the various kinds of institutions for the insane, testamentary capacity, criminal responsibility, and the medical staff of public asylums are amongst the questions discussed and subjected to considerable criticism.

The last chapters are constructive, and they contain the writer's views as to the directions in which reform should be carried out and the methods of doing so. Many of his suggestions coincide closely with those which are being advocated by various organisations interested in the problem of mental disorder. He feels strongly as to the necessity of adequate provision for the treatment of early mental cases, and he advocates legislation which will permit of simple notification to the Board of Control in incipient cases instead of certification. Such cases, he urges, must be treated quite apart from the chronic insane either "in special wards of a general hospital, approved homes, private care, or separate cottage-like buildings in the grounds of a public asylum, or private villas in registered hospitals or licensed houses," but he does not refer to separate clinics, which, perhaps, furnish the most suitable means for the treatment of early cases. The suggestion that no medical man be appointed to any post in such institutions who has not had at least two years' experience in general practice is perhaps in need of qualification, and "or post-graduate hospital appointments" might be suitably added to the suggestion. Certainly some general experience should precede entrance to the speciality. Dr. Weatherby has a good deal to say in regard to criminal responsibility, and he urges very rightly the obliteration of the MacNaghten dictum from the Criminal Law as "unscientific, untrue, and unjust."

The style of the author is extremely vigorous, the phraseology vehement, and his points are emphasised by reference to concrete cases which serve to illustrate the anomalies and injustices which are created by existing conditions. It is obvious that he feels very strongly in regard to his subject, and it is perhaps the strength of his feelings which produces in places a certain want of that scientific poise which would be expected from the writer. Thus he refers somewhat scathingly (page 62) to the pathological researches in asylums on the ground that they have not resulted in an increase of the recovery-rate. Surely the

scientific value of the pathological work which has been produced cannot be estimated merely by the recovery-rate, which obviously depends on a number of factors. It is certainly the case, as Dr. Weatherly states, that there has been a striking neglect of "individual study of the living patient," and it is a good thing to see this point emphasised; it is to be hoped, furthermore, that in the future a much more intensive study of patients and a search for the psychogenetic factors of the psychoses will be possible, but the fact that one aspect of insanity has been neglected does not diminish the value of work in other directions which has received more adequate attention.

With the central purpose of this volume all psychiatrists will be in sympathy, and it is hoped that it will have a wide circulation amongst those for whom it is intended, since it cannot fail to exert an influence upon those who read it, and it will thus help to bring about those reforms which all who are interested in the treatment of mental disorder so earnestly desire.

A sympathetic foreword to the book is provided by Dr. Theo. B. Hyslop.  
H. DEVINE.

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### Part III.—Epitome of Current Literature.

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*A Form of Pseudo-hermaphroditism in the Insane [Certain Pluriglandular Anomalous Functions Associated with Psychopathic Sexual Interests]. (Fourn. Nerv. and Ment. Dis., July, 1918.) O'Malley, Mary.*

The exact nature of the disturbance of endocrine function behind pseudo-hermaphroditism—whether somatic, psychic, or mixed—has not yet been ascertained. The evidence tends to show an inter-relation of functioning in the pluriglandular system, the hormone of one gland being related to those of all the others, with definite syndromes due to physiological or pathological changes producing hyperfunction, hypofunction, or dysfunction of these glands. The secondary sex characters are known to depend upon the gonads, and abnormalities of the sex attributes, whether in the generative or secondary sex domain, are evidence of disturbance of these glands, and hence of the endocrine system. In a broad sense the term "pseudo-hermaphroditism" may be applied to cases in which there are no evident somatic deviations in the essential sex apparatus, but the abnormalities are limited to the secondary sexual characters or to the individual's psychic character, such psychic deviations sometimes being evident only when by the development of a psychosis "the unconscious is given free expression in the dissociation of the personality," and the sexual demands, whether heterosexual or homosexual, dominate conduct. It is as understood in this wider sense that the author—who is Clinical Director of the Washington Government Hospital of St. Elizabeth—seeks to study this syndrome by the examination of eleven insane women. This series of



cases is selected from a large group of women showing decided variations in anatomical growth and development, as well as in mental development, in the direction of external hermaphroditism and hermaphroditic behaviour. There are extremely few anomalous conditions of the primary generative organs. Usually the bodily development seems to have been normal up to puberty, when male secondary sexual characteristics increased at the expense of female. Cases in which this syndrome only appeared after the menopause are excluded.

The eleven cases are separately described in detail, the chief symptomatology being alteration of the secondary sex-characters during the developmental period in the hermaphroditic direction. It is remarked that the patients conform to the classic type called Leonardesque, and especially illustrated by Vinci's "Monna Lisa," with the same facies and the same gracile hands. It can, however, by no means be said that the photographs of cases, whether nude or clothed, here reproduced, bear out this contention.

The most important symptoms in this syndrome are summed up under five heads: (1) Faulty skeletal development, male *habitus*, narrow pelvis, angularity, symmetrical but atypical features, the most striking deviation being, however, in the shape of the hands and feet, which are usually small, delicate, and well-formed, with tapering fingers—a type associated with pituitary disease. (2) Other abnormalities in general body contour, due to coarse skin, often vigorous musculature, and especially to obesity—one of the most prominent and frequent symptoms, sometimes beginning to appear even in infancy, and ascribed to under-functioning of the hypophysis, thyroid, and genital glands. (3) Disturbance of the pilous system, with excessive development of strong, coarse hair, where ordinarily there is only a light down, imitating in distribution that on the male face and body, a similar hereditary disposition being sometimes traceable, and several of the endocrinal glands probably involved. (4) Genital disturbance, with widely varying irregularities of menstruation, sometimes arrest, but few somatic anomalies of primary sex-organs beyond an infantile uterus and a few trifling external anomalies. (5) Disturbances of psycho-sexual development, with periodic reversals to a predominating homosexuality, sometimes, apparently, especially where there are manic-depressive reactions, on a bisexual foundation, the sexual inclination changing with change in the mood of the psychosis, but there is no definite mental reaction type associated with the endocrinopathies.

While regarding the traits of this pseudo-hermaphroditic group as constituting a polyglandular syndrome, the author makes no attempt to interpret it, considering as still a subject for discussion whether it is due to glandular insufficiencies or over-activities. There is here, she concludes, a great unexplored field for further research.

HAVELOCK ELLIS.

## Part IV.—Notes and News.

### MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

THE QUARTERLY MEETING of the Association was held in the rooms of the Medical Society on Tuesday, May 20th, 1919, the chair being occupied by Lieut.-Col. Keay, President.

The minutes of the previous meeting, having been printed in the Journal, were taken as read and approved.

The GENERAL SECRETARY (Major R. WORTH) read the minutes of a special meeting of medical superintendents, which was held in the same building on March 24th. These also were agreed to.

#### PROPOSED NEW BYE-LAWS.

The following new bye-laws were unanimously approved:

- (1) The seal of the Association to be affixed only after a resolution by the Council, and that it be affixed in the presence of two members of the Council and the Honorary Secretary or the Honorary Treasurer.
- (2) That a double lock be affixed to the Seal, and that the Honorary Secretary should hold the key of one lock, and the Honorary Treasurer the key of the second lock.

#### REPORT ON MAUDSLEY LECTURESHIP.

The SECRETARY read the following report:

We, your Committee, have the honour to report to the Council as requested.

We would remind the Council of its decision "That a lectureship should be founded, the lecturer to receive a medal," and that our duty is merely to formulate a detailed scheme on these lines.

We accordingly suggest as follows:

- (1) The title to be "The Maudsley Lectureship."
  - (2) The lecturer to be termed the "Maudsley Lecturer."
  - (3) The "Maudsley Lecturer" to receive a suitable honorarium (the amount of this will depend on whether the lectures are annual or biennial) and a gold medal and ribbon of the value to be decided on later, to be presented to the lecturer on the occasion of his giving his scientific lecture.
  - (4) The lecturer to be elected by the Council on the nomination of the Nominations Committee at the meeting in May of the year preceding that of the lecture.
- In the event of refusal or death of proposed lecturer a committee composed of the President, Ex-President and General Secretary shall have power to appoint.
- (5) The name of the Maudsley Lecturer to be announced at the Annual Meeting at the same time as the President announces winners of prizes.
  - (6) The name of the Maudsley Lecturer to be printed in the first page of the *Journal of Mental Science* of January of the year of the lecture immediately after the list of the Council.
  - (7) The lecturer shall be a person who has made contributions of well-recognised importance and value, bearing on the knowledge of mind and its disorders, and their prevention and treatment, be he anatomist, physiologist, psychologist, pathologist, neurologist or psychiatrist, of any nationality and of either sex.
  - (8) *The Lectures*.—The lecturer shall be required to deliver two lectures.
  - (9) The first a scientific, and the second a popular one.
  - (10) The lectures must be delivered in English.
  - (11) The subject of the scientific lecture to be an original contribution with regard to mental disease or any of the ancillary sciences. The widest possible choice of subject to be permitted to the lecturer so long as the lecture has some bearing on mind, normal or abnormal.

(12) The subject of the "popular" lecture to be on any subject connected with the hygiene of mind.

(13) As regards the question as to whether the lectures should be biennial, the members who voted for the annual lecture made the valuable suggestion that a "scientific" lecture should be given one year and the "popular" lecture the following year, and so on.

(14) As regards the time and place of the lectures it was decided that the "popular" lecture should be held at the Annual Meeting, followed the next May by a "scientific" lecture.

(15) The President shall preside at the Lecture, with the General Secretary on his right and the Treasurer on his left, as at the Quarterly Meetings.

(16) Your Committee anticipate that after all expenses are paid there will remain a sum which will accumulate from year to year, and they suggest this might be expended in two ways: (a) Assistance to assistant medical officers for original research; (b) propaganda work. Your Committee attach great importance to the latter, and suggest the printing and circulation of the "popular" lecture if deemed expedient. They would also recommend that other lectures might be given and suitable literature printed and circulated. The expenses of this could be provided out of the accumulated balance.

(17) Your Committee feel that later experience might suggest some alteration of the above regulations, and suggest that the matter should be again considered by the Council. They would remind the Council that the will of the benefactor contains no restrictions as to how the bequest should be expended.

(Signed) ROBERT B. CAMPBELL, M.A., F.R.C.P.E.,  
L. R. OSWALD, M.B., ETC.,  
C. C. EASTERBROOK, M.D., F.R.C.P.E.  
RICHARD R. LEEPER, F.R.C.S.I.,  
JAS. GREIG SOUTAR, M.B.,  
R. H. STEEN.

The Report was unanimously approved.

#### ELECTION OF NEW MEMBERS.

The following were proposed and unanimously elected members of the Association:

Fraser, Kate, B.Sc., M.D., D.P.H., Deputy Commissioner, General Board of Control, Scotland.

Knight, Mary Reid, M.A., M.B., Ch.B., Assistant Medical Officer, Paisley District Asylum, Riccarton Asylum, Paisley.

Latham, Capt. Oliver, Aust.A.M.C., M.B., C.M., Syd. Univ., Pathologist, Lunacy Department, Sydney, N.S.W.

Adey, Lieut.-Col. J. K., Aust. A.M.C., M.B., C.M.Melb., Medical Officer, Lunacy Department, Melbourne, Victoria.

Waddell, Arthur Robert, M.D., M.B., C.M.Glas. Univ., Deputy Commissioner, Medical Services, Exeter Area.

Cuthbert, James Harvey, M.B., Ch.B.Edin., Senior Assistant Medical Officer, West Ham Mental Hospital, Goodmayes, Essex.

Anthony, Mark, L.R.C.P.I., L.R.C.S.I., Assistant Medical Officer, Bucks County Asylum, Stone, Aylesbury.

The PRESIDENT called upon Dr. McDowall to read his paper: "The Genesis of Delusions: Clinical Notes."

#### NORTHERN AND MIDLAND DIVISION.

THE SPRING MEETING of the Northern and Midland Division was held by the kind invitation of Dr. Alan McDougall at the David Lewis Colony, near Alderley Edge, Cheshire, on Thursday, April 24th, 1919.

Dr. McDougall presided.

The following eight members were present: Drs. A. J. Eades, R. W. Dale Hewson, C. L. Hopkins, A. McDougall, J. Moir Mathieson, Major R.A.M.C., G. E. Mould, W. Vincent, Lieut.-Col. R.A.M.C., and T. S. Adair, and two visitors, Drs. E. Falkner Hill and A. Ramsbottom.

Apologies for inability to attend were received from the President, Lt.-Col. Keay, the President-elect, Dr. Bedford Pierce, and a number of others.

The minutes of the last Meeting were read and confirmed.

Dr. T. Stewart Adair was re-elected Secretary to the Division.

Dr. J. Geddes and Dr. R. Kirwan were elected Representative Members of Council for 1919-1920.

The kind invitation of Dr. Eades to hold the Autumn Meeting, 1919, at the North Riding Asylum, York, and of Dr. Geddes to hold the Spring Meeting, 1920, at the Mental Hospital, Middlesborough, were cordially accepted.

Dr. McDUGALL then read a paper entitled "A Group of Fits." (See p. 202.)

Col. VINCENT, Major MATHIESON and others gave their experiences, especially with regard to epilepsy caused by the war.

A paper, by Dr. PIERCE, on some present-day problems connected with the administration of asylums, was read by the SECRETARY. (See p. 198.)

A hearty vote of thanks was accorded to Dr. McDougall for his kind hospitality and for so pleasant a meeting.

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#### SOUTH-WESTERN DIVISION.

THE SPRING MEETING of the South-Western Division was held by the kind permission of Lieut.-Col. A. F. Hurst at Seale Hayne Military Hospital, Newton Abbot, on Friday, April 25th, 1919.

The following members were present: Drs. Bainbridge, Davis, Eager, Aveline, Lavers, Mary Martin, Mules, Nelis, Prentice, Soutar, Starkey, Lieut.-Col. G. E. Miles, Major Phillips, and the Hon. Divisional Secretary (Dr. Bartlett).

The visitors included Drs. Head, Waddell, Williamson, Rivers, and many Service guests at Seale Hayne.

Dr. Soutar was voted to the Chair.

Letters of regret were received from Lieut.-Cols. Goodall, Lord, and McKeay, Major Worth, and Drs. McDonald, Rutherford, and Outtersen Wood.

Dr. Bartlett was elected as Secretary.

Drs. Aveline and MacBryan were elected as Representative Members of Council.

Drs. Eager and Soutar were elected as Members of the Committee of Management.

The date of the Autumn Meeting was fixed for October 24th, 1919, of the Spring Meeting for April 24th, 1920; the place of the former meeting was left in the hands of the Secretary.

*New Member:* Annie Shortridge Mules, M.R.C.S., L.R.C.P., Assistant House-Surgeon, Devon and Exeter Hospital, proposed by Drs. Eager, MacBryan, and Bartlett, was elected a member of the Association.

A most interesting day was arranged by Lieut.-Col. Hurst. During the morning hysterical cases under treatment and cases of war neurosis were demonstrated by Lieut.-Col. Hurst, Major Venables, Capts. Gordon, Gill, Robin, and Wilkinson. This was followed by a cinematograph portrayal of cases before, during, and after treatment. After lunch and the Committee Meeting, Capt. Gordon ably debated the causes of psychasthenia, and was followed by Lieut.-Col. Hurst, who gave us much food for thought on the subject of the close alliance between hysteria and epilepsy; Drs. Head, Lavers, Eager, and Soutar took part in the ensuing discussion. A most hearty vote of thanks was accorded to Lieut.-Col. Hurst and his officers for their kind hospitality and unsparing efforts in the provision of a most instructive and interesting programme, which was greatly appreciated by all present.



## SOUTH-EASTERN DIVISION.

A MEETING of the South-Eastern Division of the Medico-Psychological Association was held at 11, Chandos Street, W. 1, on Wednesday, May 7th, 1919.

Regrets at inability to be present had been received from Sir Robert Armstrong-Jones, Sir H. Bryant Donkin, Drs. G. N. Bartlett, Fletcher Beach, W. Bevan-Lewis, A. H. Boys, A. I. de Steiger, R. Eager, F. Elkins, G. C. Fitz-Gerald, John Keay, John R. Lord, David Rice, R. Percy Smith, D. G. Thomson, and F. Douglas Turner.

*Present:* Drs. Archdale, Bower, Chambers, Collins, Evans, Fothergill, Fuller, Galpin, Haynes, Higson, Hughes, Norman, Prideaux, Stewart, Watson, and J. Noel Sergeant (Hon. Div. Sec.).

Dr. David Bower took the Chair.

The minutes of the last meeting were read and confirmed.

Drs. Bower, Craig, Daniel and Steen were elected to be members of the Council, and Dr. J. Noel Sergeant Hon. Divisional Secretary for the year 1919-1920.

Drs. Gilfillan, Norman and Steen were elected members of the Divisional Committee of Management.

Dr. Mary Rushton Barkas, M.R.C.S., L.R.C.P., Temporary Assistant Medical Officer, Bethlem Royal Hospital, 46, Connaught Street, W. 2, was elected a member of the Medico-Psychological Association.

It was decided to accept with thanks Dr. Watson's kind invitation to hold the Autumn Divisional Meeting at Elm Lodge, Clay Hill Lane, Enfield, on Wednesday, October 1st, 1919.

Dr. H. J. NORMAN opened a discussion on "Crime and Insanity." Dr. HIGSON followed with some very interesting remarks on modern procedure in connection with the mental condition of criminals. Drs. FULLER, SERGEANT and STEWART also spoke.

Drs. BOWER and CHAMBERS expressed the thanks of the meeting to Drs. Norman and Higson, and the meeting then closed, the members taking tea.

No dinner was held owing to the fact that insufficient members signified their desire to dine.

## SCOTTISH DIVISION.

A MEETING of the Scottish Division of the Medico-Psychological Association was held in the Hall of the Royal Faculty of Physicians and Surgeons, Glasgow, on Friday, March 21st, 1919.

*Present:* Lieut.-Col. Keay, Major Hotchkis, Capt. Patch, R.A.M.C., Drs. Buchanan, Carre, Easterbrook, Kerr, T. C. Mackenzie, McRae, Macdonald, Oswald, G. M. Robertson, Maxwell Ross, Shaw, and Surgeon-Commander R. B. Campbell, R.N., Divisional Secretary.

Lieut.-Col. Keay, R.A.M.C., President of the Association, occupied the Chair.

The minutes of the last Divisional Meeting were read and approved, and the Chairman was authorised to sign them.

The SECRETARY submitted a letter of acknowledgment received from Mrs. Reid, thanking the members of the Division for the kind letter of sympathy sent to her.

Apologies for absence were intimated from Drs. Thomson, Carr, Eager, Lord, Mills, Skeen, Alexander, Sutherland, Dods Brown, Orr and Crichtlow.

The CHAIRMAN stated that Dr. Donald Ross, who had come to Glasgow to attend the meeting, had been taken ill, and the Secretary was asked to write to Dr. Ross expressing the sympathy of those present, and to send him their best wishes for a speedy and complete recovery.

The PRESIDENT thanked the members for the kind letter which he had received regarding his recent illness.

Dr. J. H. Skeen and Dr. T. C. Mackenzie were unanimously elected Representative Members of Council for the ensuing year, and Dr. R. B. Campbell was elected Divisional Secretary.

Dr. W. M. Buchanan was recommended to the Educational Committee of the Council as an Examiner for the Certificate in Psychological Medicine.

A general discussion took place on matters at present affecting asylum administration, and a scheme of reduced working hours for the nursing staff in asylums was recommended.

The SECRETARY pointed out that a committee, drawn from recognised medical bodies in Scotland, had been appointed for the purpose of considering the proposals under discussion for the establishment of a Ministry of Health, and that he considered that the Scottish Division of the Association had strong claims to be represented on such a committee. After some discussion it was unanimously agreed that the Secretary should communicate with the Secretary of the committee requesting that the Division should be represented, and Lieut.-Col. Keay was nominated as representative.

It was also agreed that a small committee, composed of Lieut.-Col. Keay, Dr. G. M. Robertson and Dr. Campbell should be appointed to act as a Watching Committee *re* the Ministry of Health Bill.

A vote of thanks to the President for presiding concluded the business of the meeting.

#### CORRESPONDENCE.

The following communication from Sir H. Bryan Donkin has been forwarded to the Editors for publication :

It is greatly to be regretted that my article on the " Factors of Criminal Actions " was published in the *Journal of Mental Science* only a few days after the lamented death of Dr. Charles Goring. This article consisted mainly in a reply to Dr. Goring's criticisms of a paper by me which he published in the *Journal* for April, 1918. My reply was written in the summer of 1918, and the proof was corrected by me many months before the article was printed off for the April number of this year, some time previously to Dr. Goring's death on May 5th.

But for this unavoidable concurrence of dates my article would have been published later, with an expression of my personal sorrow for the loss of Dr. Goring and my regret that no further elucidation of the controversy between us could now be made.

H. BRYAN DONKIN.

June 12th, 1919.

#### PRISON REFORM.

##### THE POLICY OF THE HOWARD ASSOCIATION.

IN a statement of policy, just issued, the Howard Association, which recently celebrated its jubilee, says that the two main reasons for maintaining a penal system are the protection of the community and the reformation of the offender; and because society cannot obtain real protection unless the offender either be permanently segregated or permanently reclaimed, it follows that the chief business of our penal methods is to secure the reformation of offenders. To this end the Association urges that prison governors and their subordinates shall be chosen as possessing special aptitude for reclaiming men and women, and that a certain amount of freedom to experiment shall be permitted. The Association instances the striking results recently obtained in American prisons, notably at Sing Sing, New York, and in British prisons advocates abolition of the " Silence Rule," which is seldom observed, and breeds deceit in prisoners and warders alike; the shortening to a very brief term of the period of separate confinement; more free intercourse from judicious persons from outside; extension of the functions now exercised by the paid prison Chaplain to persons of all denominations, paid or unpaid, having the necessary gifts and calling; adoption of the Indeterminate Sentence, ensuring that offenders shall be released when they are fit to be released, and the adoption of the Parole System, that they may receive guidance during the early days of liberty. An extension of the Probation System is advocated, together with the appointment of more and better-trained and better-paid Probation Officers. The Association shows that the easy method of making prison the alternative to payment of a fine bears much more heavily on the poor than the rich, and urges

that in certain well-defined cases it shall be compulsory on Justices to allow time in which to pay fines. In cases of fraud, theft, and embezzlement, magistrates should more often order compensation to be paid by the offender, by instalments, as in the case of civil debt. This course would supply the element of deterrence, now often felt to be lacking in the system of probation. Copies of the Statement of Policy of the Howard Association may be obtained on application to the Secretary at 43, Devonshire Chambers, Bishopsgate, E.C. 2.

#### OBITUARY.

JOSEPH WIGLESWORTH, M.D., F.R.C.P.,  
*Former Medical Superintendent, County Asylum, Rainhill, Liverpool.*

By GEO. H. SAVAGE.

One by one our senior fellows and former leaders are dropping off, and it is our duty to note and record the work they have done. Time passes so quickly that the milestones of progress are not noticed by the hurrying workers of to-day.

First I will refer to the official position of Dr. Wiglesworth.

After a distinguished studentship at Liverpool and St. Thomas's Hospital he was for a time House-Surgeon at the Royal Infirmary at Liverpool. He was then appointed Assistant Medical Officer, under Dr. Rogers, at the County Asylum, Rainhill, Lancashire. After some years he succeeded Dr. Rogers as head of the asylum, and was appointed Lecturer on Insanity at the Liverpool School of Medicine. He was President of the Association 1902-1903, and Member of the Neurological Section of the Royal Society of Medicine. He contributed to Tuke's *Dictionary of Psychological Medicine* and to our Journal. He also wrote an article in *Brain* and contributed to the *Liverpool Medical Journal*. He was a regular attendant at the meetings and spoke occasionally at them.

Next I must refer to his original work. This was both pathological and clinical. He studied very carefully the histology of general paralysis of the insane, and described very accurately the vascular and other changes present in that disease. The relationship of it to syphilis had not been established, but Wiglesworth with some diffidence traced a connection between the two. Probably he will remain known as the first to point out that pachymeningitis is not an inflammatory disease, and all authorities now recognise his work on subdural hæmorrhages. He contributed several articles on the subject which appeared in the *Journal of Mental Science*. Another very important contribution by him was on adolescent insanity and the relationship of delusions and hallucinations to the mental disorders. He recognised the teaching of Hughlings Jackson showing that defect in the highest centres of control led to over-action of the lower centres, and he inferred that maniacal conditions depended on disorder in the highest centres. On the other hand, the mental affections chiefly marked by sensory disorders he believed to originate in disease of the organs of sense and their representative centres. This is certainly supported by the fact that there may be persistent hallucinations of all kinds without any apparent defect of memory or intellect apart from the delusions depending on the sensory disorders.

Wiglesworth contributed to the Journal various clinical records of interest. He supplied elaborate tables in reference to uterine disease and insanity—tables which are still of value. His observations and records are models of careful work; whatever he did he did thoroughly.

As President of the Association he took for the subject of his address "Heredity and Evolution"—he was, at the time, a firm believer or follower of Weismann—but the most valuable part of the address was the special reference to the influence of the male and female parent on the neurotic tendency of the offspring. He confirmed the general belief that the mother passed on the neurotic taint to the female children more than to the males, and though the father did to some degree pass on a greater tendency to nervous disorders to sons than to daughters, yet the daughters run a great risk even from fathers.

He was not able to establish a special tendency to develop similar symptoms—that is, similar forms of disorder in parent and offspring.

He very distinctly believed in the transmission of certain acquired habits such as alcoholism, but I think he has hardly established his point, though I agree with him in believing that a general poisoning by alcohol or syphilis must affect the germ-plasm and thus the next generation.

Here, then, we have a brief outline of the work done for our branch of the profession, but for a complete knowledge I must refer to Tuke's *Dictionary*, to the index of our Journal, and to the index of *Brain*.

Wiglesworth proved himself to be a good administrator as well as a scientific worker.

He wrote on homicidal impulse apart from active symptoms of insanity, and by fate he nearly provided an example in himself. He was attacked by a patient who had prepared a sharp puncturing weapon. A wound in the neck was made dividing the external carotid. With great calmness he recognised the injury and compressed the vessels, and with the help of his colleagues controlled the hæmorrhage till a Liverpool surgeon came, who had to tie the common carotid. Wiglesworth recovered from the severe shock, but it seemed to leave him an older and altered man, and he retired on a pension.

Having discussed him medically it remains to describe the man and his other aspects. He was a shy, retiring man, and apparently rather weak of physical power, but in reality he had a great reserve of force, and he could undertake long and arduous walks and excursions in pursuit of his natural history hobbies.

He was not given either to sport or to general social pleasures. Married to a lady with similar tastes his home sufficed for him.

When at Rainhill he developed a very complete garden of British plants which were arranged according to their natural orders, and he made ingenious plans to suit each to its natural habitat. After retiring from active medical work he devoted himself to bird study, and became an authority on the birds of Somersetshire. He made an adventurous expedition to St. Kilda and wrote a book on its birds.

Thus life passed placidly till his only son was killed in the war. This was a crushing blow.

His end was characteristic of the man, as I have heard he was in pursuit of a kestrel's nest on the cliffs and fell, and his dead body was found at their base.

So ended almost as he would have wished it the active life of a scientific recluse.

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#### APPOINTMENTS.

Simpson, E. S., M.C., M.D.Edin., Medical Superintendent, East Riding Asylum, Beverley, Yorks, *vice* Dr. Archdale, resigned.

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#### NOTICE TO CONTRIBUTORS.

*N.B.*—The Editors will be glad to receive contributions of interest, clinical records, etc., from any members who can find time to write (whether these have been read at meetings or not) for publication in the Journal. They will also feel obliged if contributors will send in their papers at as early a date in each quarter as possible.

Writers are requested kindly to bear in mind that, according to LIX(a) of the Articles of Association, "all papers read at the Annual, General, or Divisional Meetings of the Association shall be the property of the Association, unless the author shall have previously obtained the written consent of the Editors to the contrary."

*Papers read at Association Meetings should, therefore, not be published in other Journals without such sanction having been previously granted.*





THE  
JOURNAL OF MENTAL SCIENCE  
[Published by Authority of the Medico-Psychological Association  
of Great Britain and Ireland.]

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No. 271 [NEW SERIES  
No. 235.] OCTOBER, 1919. VOL. LXV.

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Part I.—Original Articles.

*Psychiatry a Hundred Years Ago : with Comments on the Problems of To-day.* The Presidential Address at the Annual Meeting of the Medico-Psychological Association of Great Britain and Ireland, held at York, July 22nd, 1919. By BEDFORD PIERCE, M.D., F.R.C.P. Lond., Medical Superintendent, The Retreat, York.

THE theme of the address I am about to give—if anything so discursive can be said to have a theme—is the medical treatment of the insane during the period of transition and reform at the end of the eighteenth and beginning of the nineteenth centuries.

In the latter part of the reign of George III many treatises on insanity were published, most of them possessing a literary grace not common in medical works to-day. They abound in reports of clinical cases and details of the treatment, and the appearances on *post-mortem* examination are frequently recorded. Probably the public interest taken in the king's illness helped to stimulate this remarkable output. The volumes are full of interest, and much that they contain seems wonderfully modern : nevertheless, I have not found it easy to enter into the spirit of the age. Old doctrines still survived, and the new doctrines were as yet young and struggling for recognition.

During the early part of this period medical treatment was based upon the hypothesis that acute insanity was due to inflammation of the brain and its membranes. It was therefore considered essential, by whatever method, to reduce the supply of blood to the head. This can be illustrated by the treatment of George III himself in 1789. His physicians had quarrelled in such an unseemly fashion that the House of Lords appointed a committee to examine them. We learn, however, from the report that they had at least been unanimous on one occasion, namely, when they decided to blister the King's legs to relieve his acute excitement. The result is duly recorded : "The pain undoubtedly

made him more unquiet, and increased the necessity for coercion, but did not appear to increase or diminish the grand malady." (1)

Similarly, the practice of blood-letting was considered of extreme value in insanity. In reference to this, in 1789, Harper writes: "I am fully satisfied of the expediency of this preliminary step, being confident that there never was nor ever will be a mania in which venesection, less or more, would be improper at the beginning." (2) Pinel himself says: "It is a well-established fact that paroxysms of madness thus anticipated are in many cases prevented by copious bleeding." (3) In 1811, Crowther, the surgeon to Bethlem, claimed to have bled 150 patients at one time without untoward result. (4) He also recommended emetics, quoting a case of hypochondriacal melancholia relieved entirely by their use. The patient took sixty-one vomits in the course of six months, and for eighteen nights one every evening, and yet made a perfect recovery! (5) This view of the pathology of insanity was supported by the *post-mortem* findings, which frequently described hæmorrhagic points in the substance of the brain.

We get some idea of the routine practised in Mr. Haslam's evidence to the House of Commons Committee in 1815. "The period of physicking continues from the middle of May, regulated by the season, to the latter end of September, two bleedings according to discretion, half a dozen emetics if there should be no impediment to their exhibition, and for the remainder of the time to Michaelmas a cathartic once a week." (6)

The treatment of insanity was founded on the antiphlogistic theory which at that time was generally held, and we must not hastily pass judgment upon those who conscientiously accepted it, and did the best they could. We may be inclined to think certain practices barbarous, but they were not intentionally cruel, nor were those who prescribed them indifferent to the suffering they caused. In our own times, theoretical considerations have suggested methods of treatment that may be criticised adversely by our successors. For instance, seeing that convalescent patients frequently possess an increased number of white blood-cells, it was suggested that an artificial leucocytosis might produce recovery. Turpentine or other agents have, therefore, been injected in order to produce an abscess—a line of treatment founded upon the gratuitous assumption that the leucocytosis in the two cases was similar in nature. The underlying thought here is akin to that of Dr. Joseph Mason Cox, who recommended inoculation with smallpox or the itch, and the irritation of the skin by tartar emetic, blisters or setons, and who says: "Certain it is that if any considerable commotion, any violent new action can be excited in maniacal complaints by whatever means, the mental derangement is often considerably relieved or permanently improved." (7)

It would be difficult to find the teachings of the old school more concisely expressed than in Dr. Cox's little volume, *Practical Observations on Insanity*, published in 1804. The modern reader is offended from start to finish, and yet the book professes to state rules which will lead to "a more humane and successful method of cure."

The importance of controlling the patient is first mentioned, and we are told that it is of the essence of management to make impressions on the senses, and that the grand object is to procure the confidence of the patient, *or* excite fear! Note the alternatives! "Pious frauds" are recommended. (8) One instance may be recounted—that of a gentleman who thought his housekeeper had tried to kill him by means of poison in his shirt. It was arranged that she should be arrested in his presence, and she was dragged away, making loud protestations of innocence. A bogus analysis of the shirts confirmed his suspicions, and after a solemn consultation antidotes were prescribed, and we are told that he recovered in a few weeks.

That is bad enough; but the next method which Cox strongly recommends is even more objectionable. It is the use of a circular swing, invented, we are told, by Dr. Erasmus Darwin, by means of which a patient firmly strapped in a chair or upon a bed could be made to rotate round a central beam at any desired pace.

The treatment was designedly terrifying, but before passing judgment we should in fairness to Dr. Cox read some of his cases. I will quote two:

"Mr. —, æt 40, of a florid complexion, very muscular, became gradually depressed, then unusually gay and flighty: previous to these symptoms he had been eccentric, ingenious, good-tempered, remarkable for an accurate, retentive memory, and for feats of the palestra. . . .

"For six weeks he had resisted all my attempts to introduce medicines, possessed a voracious appetite, while days and nights were passed in alternations of struggles from coercion and violent vociferation. Judging from all the attendant circumstances no hazard could attach to the employment of the swing, this was determined on, but a strong party was necessary to place him in it. The first five minutes produced no kind of change, and the novelty seemed to amuse, but on increasing the motion the features altered, and the countenance grew pallid, and he complained of sickness and prayed to be released: after a few rapid gyrations more vomiting succeeded, his head fell on his shoulder, and his whole system seemed deprived of vigour and strength: from the swing he was carried to bed by a single attendant, where he immediately fell asleep: slept nine hours without intermission, and awoke calm and refreshed. . . . He soon became convalescent, and advanced to the perfect enjoyment of health and reason." (9)

Another case. Mr. —, æt. 22, naturally grave, reserved, his life a model of probity and virtue, became depressed, seriously mutilated himself, and passed into a state we should call melancholic stupor; forcible feeding with spouting was tried under great resistance, and



finally the rotating swing as a last resource. It caused alarm, then nausea and vomiting; he begged to be liberated, but would not promise to take his food, so the swing was continued more rapidly. He then promised acquiescence, was put to bed and slept some hours. Two or three times the swing was repeated, till at length he became docile, and at last body and mind were perfectly recovered. Dr. Cox concludes: "I am confident he owes his life and reason to the swing." (10).

The swing was recommended by many physicians of experience. Dr. Young, of optical fame, and a member of the Society of Friends, as Sir James Crichton-Browne recently pointed out, advocated its use in 1809 (11); and in the report of the 1815 Committee of the House of Commons it is stated that Mr. Finch at Laverstock near Salisbury, "finds the rotating chair, producing nausea, most useful, as the pain it excites takes the patients off to it rather than the disease." In justice it must be added that the general condition of the patients in this establishment was said to be very good. Every possible amusement was provided: billiards and backgammon indoors, bowls, cricket, coursing and riding out of doors, and Mr. Finch appeared to be "a humane man and a man of sense." (12) It is interesting to note that in Morrison's *Lectures*, published in 1828, an illustration of a swing was given, that every private asylum might become properly equipped. (13) It is difficult to understand how such a cruel method of treatment became so popular, but in particular I should like to know how it happened that the swing was found to be such a powerful hypnotic. Something seems wrong somewhere!

The striking change in the treatment of the insane which began as the eighteenth century was closing can, I think, be traced to three causes.

First there was the great humanitarian movement, which awakened sympathy with all human suffering, even in the despised and degraded—prisoners, slaves, and lunatics. Perhaps this movement reached its high-water mark in our own country, but it was felt throughout western Europe. Secondly, there was the social reform, initiated in France, the demand for liberty, equality, fraternity, which penetrated even to the prison asylums of Paris. Thirdly, there was a gradual enlightenment of medical opinion, which led to the discontinuance of much that was grievous and painful in asylum practice.

It is not my intention to re-tell at any length the story of the reform in the treatment of insanity. This was not the work of one man or of one nation.

So far as I can ascertain, actual priority belongs to Italy. Between the years 1774 and 1788 Vincenzo Chiarugi, assisted by Daquin of Chambéry, introduced new methods at the Hospital Bonifacio in Florence, where chains and fetters were abandoned, and patients were encouraged to work. New regulations, embodying these reforms, were approved by the Grand Duke Piétro Leopoldo.

But the premier place undoubtedly belongs to Philippe Pinel. He not only transformed the conditions at the Bicêtre and Saltpêtrière in Paris, but he convinced the world by his writings that the old methods were wrong and futile. Pinel's treatise on *Aliénation Mentale*, published in 1801, takes the highest place in the literature of his time dealing with insanity. It was translated into English by Dr. Davis of Sheffield in 1806.

I should have liked to have referred to many incidents in the life of Pinel, but time forbids. He was first led to study insanity by the mental illness of a friend, for whom all methods of treatment failed, and who finally escaped into the forest and died of inanition. Clashed in his hands and untouched by wolves was found the one of Plato's works discussing the immortality of the soul!

Pinel was the hero of a wonderful chapter in the history of medicine, with which I fancy many of our younger members may be unfamiliar. This was the reform at the Bicêtre, in 1793, during the darkest hours of the French revolution. Pinel was suspected of harbouring aristocrats, and had the utmost difficulty in obtaining permission to liberate his patients from their chains. It was to Couthon, even in the reign of terror a conspicuously repulsive character, that Pinel, during a personal investigation, uttered the words which stand true for all time: "Citizen, I have a conviction that the insane are only intractable because they are deprived of air and liberty." (14) The same day he began the removal of chains from fifty patients, the first of them an English sea-captain, whose history was unknown, but who had been in chains for upwards of forty years.

I need not give many details of the establishment of the Retreat, for the last meeting of the Medico-Psychological Association held at York was at the time of its centenary, and much was then said of its early days.

The project was first raised in March, 1792, the land was purchased two years later, and the Retreat was opened in 1796, long before Pinel's work in Paris was known in York.

Two members of the Society of Friends were chiefly instrumental in its establishment—William Tuke and Lindley Murray.

William Tuke was sixty years of age when he first proposed to build the "retired habitation" subsequently named the Retreat. He was an active, determined man, with liberal ideas on the subject of education, and his portrait, reproduced by his great-great grandson, H. S. Tuke, R.A., shows benevolent, yet strong features.

Lindley Murray, the well-known author of Murray's *Grammar*, was an American friend who had settled in York. He was an invalid, confined entirely to bed, but deeply interested in all philanthropic works. In a quiet way he contributed much to the foundation of the Retreat, but

his energetic and strong-willed friend, William Tuke, actually carried the project through, in spite of much opposition and misunderstanding. Even William Tuke's wife is reported to have said, "Thou hast had many children of thy brain, William, but this last one will be an idiot."

What he accomplished would not have been so widely known had not Samuel Tuke, his grandson, published in 1812 *The Description of the Retreat*. This was a scholarly work and is well worth careful perusal to-day. We possess at the Retreat a copy, formerly the property of the late Sir Arthur Mitchell, the Scotch Commissioner, who wrote at the time of the centenary: "The whole work of my life has been coloured by Samuel Tuke's *Description of the Retreat*. . . . The title misleads. It is much more than a description. It is a presentation of the principles which should guide us in treating and caring for the insane." (15)

The reader who acquaints himself with the writings of Philippe Pinel and Samuel Tuke will realise that a complete change in outlook had been inaugurated. It was not merely the introduction of humane methods, the cessation of cruelty, and abandonment of the brutal system of coercion, but the recognition and fearless application of a new principle. This they called "moral treatment," by which they claimed that more could be done for the insane than by drugs or discipline. They asserted that the psychical environment surrounding a patient was of no less importance than the physical conditions, and that the course of insanity was influenced by mental and moral considerations. I must not follow up the subject, but the assertion was profoundly significant.

It is interesting to read in Tuke's description the account of their attempts to cure insanity by the therapeutical methods of the day.

The following passage seems wonderfully modern: "The physician first appointed to attend the Retreat was a man equally distinguished by medical knowledge and indefatigable perseverance. He possessed too . . . a highly benevolent and unprejudiced mind. . . . He determined to give a full trial of the means which his own judgment might suggest, or which the superior knowledge and experience of others had already recommended. But the sanguine expectations, which he successively formed, of benefit to be derived from various pharmaceutical remedies, were in great measure as successively disappointed; and although the proportion of cures in the early part of the history of the institution was respectable, yet the medical means were so imperfectly connected with the progress of recovery that he could not avoid suspecting them to be rather concomitants than causes. Further experiments and observations confirmed his suspicions, and led him to the painful conclusion (painful alike to our pride and to our

humanity) that medicine as yet possesses very inadequate means to relieve the most grievous of human diseases." I fear that the concluding sentence is still true, although a hundred years have passed since it was written.(16)

This passage refers to Dr. Thomas Fowler, known to every medical man by the alkaline solution of arsenic which bears his name, and which, by the way, was probably discovered by one Mr. Hughes, in analysing a secret remedy known as Dutch drops (17). But Fowler introduced it to the world, in a striking volume, published in 1786, which dealt with the various uses of arsenic. He was a remarkable man, a keen observer, devoted to experimental research. A citizen of York, he practised there for many years as a chemist. At the age of forty-two he graduated in medicine at Edinburgh, and settled for some years in Stafford. But he returned to York, and in 1796, "without his solicitation and even without his knowledge," was appointed physician to the Retreat. He died in 1801, and it is stated he left in manuscript notes of 6,000 cases. His published works breathe throughout the scientific spirit, and he recites his cases concisely and without bias, failures and successes alike. Any drug or therapeutic agent which he investigated was administered singly, under conditions as similar as possible, and he faithfully recorded the results for all to see and judge for themselves. The Retreat was fortunate in its first physician.

Samuel Tuke explains that Dr. Fowler's successors also tried "various means, suggested either by their own knowledge and ingenuity or recommended by later writers: but their success has not been such as to rescue this branch of medicine from the charge, unjustly exhibited by some against the art of medicine in general, of its being chiefly conjectural." (18)

In connection with this last sentence it may be interesting to note that when it was written the Rev. Sydney Smith was living at Heslington, less than a mile from the Retreat. His scathing remark that medicine is the "art of putting what we know little into bodies of which we know less" may easily have been in Samuel Tuke's thoughts.

Sydney Smith took a great interest in the Retreat, and when the *Description* was published, he drew attention to it in the delightful essay, "Mad Quakers," which appeared in the *Edinburgh Review*. This essay probably did more than anything else to acquaint the general public with the Retreat's existence and the principles for which it stood.

I should not like to convey the impression that the Retreat was the only institution in England conducted on humane and enlightened principles. Mention has already been made of Mr. Finch's House at Laverstock, Salisbury, and, besides this, high praise was given to Bristlington House, Bristol, in the 1815 Report to the House of



Commons. This was opened in 1804 by Dr. Edward Long Fox, who had had long experience in the treatment of insanity. The centenary volume of Brislington House contains many interesting details of its early days, but I have not seen any published accounts of Dr. Fox's medical practice. He was a man of high principle, and it is noteworthy that, although he was a member of the Society of Friends, he appointed a Church of England clergyman as chaplain, and was, I believe, the first to provide regular religious services for the insane.

In estimating the results of treatment we are confronted with the difficulty as to being sure that all the essential facts are known to us. Rarely can we be certain what would have happened if this instead of that had been done. This is also the problem of history.

Suppose, for instance, that Margaret Tudor, on her way to Scotland, instead of riding in state into St. Mary's Abbey, had fallen from her horse as she passed through the gateway which still blocks the traffic outside Bootham Bar, and had never married James IV of Scotland! What would have been the course of history with no Mary Queen of Scots, no Lord Darnley to be murdered, with no James the First of England, and no Stuart line of kings? We can only say we do not know!

The same difficulty meets us in estimating the consequences of our own acts. We find it impossible to measure the issues of a chance meeting or a casual remark; we are bewildered with the complexity of life, and we are tempted to accept the philosophy of the old Persian singer:

" 'Tis all a chequer-board of nights and days  
Where Destiny with men for Pieces plays,  
Hither and thither moves, and mates and slays,  
And one by one back in the closet lays.

" The moving Finger writes, and having writ  
Moves on: nor all thy Piety nor wit  
Shall lure it back to cancel half a line,  
Nor all thy Tears wash out a word of it."

In medicine the problem is similar. There are so many incalculable elements that we can rarely foretell with precision the results of any line of treatment. This fact is very apparent when we consider the question of the use of sedative drugs.

A hundred years ago only three of these were in use—opium, hemlock, and henbane; and opinion was greatly divided with regard to their value. Haslam strongly condemned opium, saying that "many narcotic poisons have been recommended for the care of madness, but my own experience of these remedies is very limited, nor is it my intention to make any further trials." (19) Pinel, referring to the contradictory opinions on this subject, suggested that the experi-

ments should be repeated with proper attention to the specific distinctions of insanity. (20)

At present I suppose that more than a hundred sedatives are advocated for sleeplessness and mental excitement, and the problem of their use is more complex than ever before, and as yet no clear and well-established principles are available to guide us in their use.

It is, of course, recognised that chemical restraint is generally harmful, that drug habits are easily acquired, and that sedatives dull the faculties and mask symptoms. Moreover, all physicians in hospitals for the insane know that many newly-admitted patients will not recover until the hypnotics given before admission are withheld. Sedatives, nevertheless, give temporary relief, and it would be cruel to forbid them, unless it can be shown that they are hurtful.

Yet the extreme opinion of Haslam, already quoted, is shared by many present-day physicians. Prominent amongst these is Dr. Hitchcock, late Medical Superintendent of Bootham Park, York, who published in 1900 in the *Journal of Mental Science* a striking article summarising the results of treating 206 cases of acute mania without any sedatives whatever.

I have Dr. Hitchcock's permission to give some interesting details, explaining how he found himself in opposition to the current practice of the day. When he began to practise chloral was much lauded, and at his first asylum appointment he found that this drug was given at the discretion of the nurses. Without telling them, he substituted for it camphor and chloroform water, which proved equally useful. Later, at Bethlem, he found chloral, hyoscyamine, and cannabis indica freely used. But there he obtained valuable help from Smeeth, the head attendant, who had carefully watched the results, and was satisfied that the patients were not benefited by drug sleep. Subsequently he was appointed to another institution, in which the use of chloral was rampant on both sides of the house, and 16-ounce stock-bottles were filled as often as needed, and dispensed by the night staff at their discretion. Dr. Hitchcock first gradually reduced the dose, and then substituted camphor, and later salt solution. When he had fully convinced the staff that the new "sleeping draught" was fully as successful as the old, both for recent and chronic patients, it was possible to "own up," and explain that for some time past no sedatives whatever had been used! For the next twenty-five years he allowed no sleeping-draughts of any kind, yet the recovery-rate at Bootham Park during this period was a high one.

At the Retreat we do not use narcotic drugs in newly admitted cases, and only rarely are they prescribed, when ordinary measures have been persevered with for a long period and failed. It is only fair to say that in some exceptional cases great benefit has seemed to follow. I cannot,

therefore, claim to be a total abstainer, like my friend Dr. Hitchcock ; but I support his testimony, and believe that the stand he has taken will make his name memorable in time to come.

Even, however, if it were demonstrated that drugs, in the main, were useless and probably hurtful, it would not follow that they had no place in psychological medicine. There are cases in which the intensity of mental suffering calls for immediate relief, even if only temporary. It is unlikely that all drugs are valueless : the problem is to find out their precise functions and limitations.

I incline to think that members of our Association could investigate this question to good purpose. We have many facilities for such a research. Our patients live under very uniform conditions : in the nursing staff we have trained observers, able to collect and record facts, and the inquiries could be conducted on a sufficiently large scale to eliminate many disturbing factors.

We have to admit at the outset that our present classification of mental disorders is not sufficiently accurate to enable us, in the significant words of Pinel, "to be sure that similar things are being compared." But practical therapeutics cannot wait until the ætiology of disease is fully known, and its pathology is complete. Physicians should really be able to speak with no uncertain voice regarding the use of narcotic drugs. Will not some of our younger members take up this subject for systematic investigation ?

The striking success obtained at Guy's Hospital in studying the effect of drugs in the treatment of acute rheumatism justifies the opinion that a somewhat similar inquiry into the value of sedatives might be of great service in psychiatry.

How this should be conducted it would be presumptuous of me to say ; but I may perhaps suggest lines on which some inherent difficulties might be avoided. We recognise that though the external conditions of patients may be precisely similar in regard to surroundings, exercise, and daily routine, internal conditions may be utterly diverse. Now, it is useless to accumulate facts concerning 100 or even 1,000 individuals, if in essentials they have little in common. At the outset, therefore, it would seem advisable to limit the inquiry to groups of cases in which psychical factors are of secondary importance—such as acute delirium, the nocturnal excitement in senile insanity, the agitated melancholia of the climacteric, and possibly maniacal excitement in well-marked recurrent cases. Two groups of similar cases might then be compared, one taking no drug, the other any drug that might be selected. I am aware that the risks of drawing wrong conclusions would by no means be eliminated, yet I am sure that results thus obtained would be of greater value than the individual opinions of even the most observant people.

Another problem that confronted physicians at the commencement

of the nineteenth century was the alcohol question, which from the dawn of history has troubled mankind.

Let me give the following extract from a letter written in Egypt nearly 3,500 years ago, now in the British Museum (21): "Whereas it has been told me that thou hast forsaken books and devoted thyself to pleasure: that thou goest from tavern to tavern smelling of beer at the time of the evening. If beer gets into a man it overcomes his mind. . . .

"Thou knowest that wine is an abomination, that thou hast taken an oath that thou wouldst not put liquor into thee. Hast thou forgotten the resolution?"

A twentieth century parent might make a similar appeal, so little have conditions changed.

Within the last hundred years, however, some advance has been made. The habits of the people have improved, drunkenness is no longer respectable, gentlemen are not now carried helpless to bed after dinner, and teetotallers are not considered a menace to society. Nevertheless, the problem is still unsolved, and all who are interested in the welfare of the British people—I fear I must on this occasion say British rather than English—deplore the drinking customs of our countrymen. Physicians, employers, social workers are at one in this respect. The wastage from intemperance is incalculable, and yet we see before us increasing industrial competition with nations such as the States and Japan which are relatively abstemious. I am no pessimist; yet I cannot do otherwise than view the coming industrial conflict with grave anxiety whilst we handicap ourselves so heavily. The social and economic aspects of this problem are not, however, within the scope of this address, and I turn to its medical aspect.

It is impossible to estimate the number of persons who may justly be considered intemperate or addicted to drink. There are no trustworthy data, but probably the number is vastly greater than we are apt to assume. The great majority do not consult any physician and relatively few come under the cognizance of the police. The statistics of police-court convictions, moreover, are apt to vary with the vigilance of the chief constable, or the sentiments of the members of the Watch Committee.

In 1900 the average amount of alcohol consumed per head was calculated to amount to 2·08 gallons yearly. This included everybody—men, women and children. But if children and adult abstainers are excluded, and if we make allowance for the fact that women as a rule drink much less than men, and remember that a large part of the community is strictly abstemious, we are left with a minority whose consumption of alcohol must clearly be excessive.

The word "inebriate" is unfortunate as it suggests actual drunkenness,



whereas there may be dangerous alcoholic addiction without gross signs of intemperance. As Sir William Collins has recently pointed out, the term "addiction" is very appropriate, for the *Addictus* was a debtor who, in Roman law, was handed over to his creditor, and the word implies a limitation of freedom or some degree of slavery.

This morbid condition, of course, is essentially the concern of psychiatry. It is virtually a disease, although, when the exciting cause is removed, no symptoms may be discovered, and although no pathological findings assist in its recognition.

Experience tells us that the potential inebriate should be treated early or there will be little hope of preventing confirmed addiction. But, unfortunately, effective treatment can rarely be obtained, early or late, and the position is not substantially altered since Haslam in 1808 dealt with this question in language which is appropriate to-day :

"Thus a man is permitted slowly to poison and destroy himself ; to produce a state of irritation, which disqualifies him from any of the useful purposes of life ; to squander his property among the most worthless and abandoned ; to communicate a loathsome and disgraceful disease to a virtuous wife ; to leave an innocent and helpless family to the meagre protection of the parish. If it be possible the law ought to define the circumstances under which it becomes justifiable to restrain a human being from effecting his own destruction, and involving his family in misery and ruin. When a man suddenly bursts through the barriers of established opinions ; if he attempts to strangle himself with a cord, to divide his larger blood-vessels with a knife, or swallow a vial full of laudanum, no one entertains any doubt of his being a proper subject for the superintendence of keepers ; but he is allowed, without control, by a gradual progress, to undermine the fabric of his health, and destroy the prosperity of his family." (22)

Unfortunately, to this day, no satisfactory means have been devised to prevent or arrest alcoholic addiction. The Inebriate Acts are practically useless, especially in the early stages of the disorder, and to wait until some offence has been committed before adopting remedial measures generally means disaster. The position, moreover, is one of extreme delicacy. The patient often refuses to admit the necessity for treatment ; he or she may be in good health and possess an attractive personality. Hardly anyone knows that indulgence is becoming habitual, and probably those who do know are prejudiced observers.

If early treatment is to be obtained it must clearly be on a voluntary basis and in strict privacy, for no one can afford to be branded as an alcoholic.

Treatment, to be effective, means a long and patient investigation into underlying causes, and this alone makes serious demands upon the physician and his helpers. No one with experience in this depart-

ment of medicine will under-rate the amount of time and trouble needed to help the patient along the difficult uphill road towards recovery. At present such treatment is altogether outside the reach of the majority of those who need it.

If the suggestion in an article by my old friend, Mr. Theodore Neild, of Leominster, were adopted, and a consultation bureau were established in every large centre of population, much might be done to give the necessary help. (23) The staff of the bureau would consist of a secretary—preferably a trained lady social worker—with such clerical assistance as might be necessary, and visiting physicians possessing special experience in this subject. It would then become possible for anyone to obtain confidential advice either for himself or for a relative or friend, whilst the bureau would be able to secure the help of other medical services and lay organisations as occasion might demand.

I am sanguine enough to believe that with assistance such as this not a few patients would completely recover. The return to useful work of many who otherwise would be a burden upon society would, even from a financial point of view, justify the expense incurred.

It is, however, important to realise that this malady cannot be considered apart from other forms of mental instability. This Association in 1914, and again this year, urged the establishment of clinics, or hospitals for nervous disorders, in order to provide early treatment of unconfirmed mental trouble; the Board of Control have reported to the same effect, and the Legislature is already taking up the subject. I would submit that the proposed consultation bureaux be affiliated with or become a special department of the new clinics. It is undesirable that alcoholic and drug addiction should be dealt with altogether apart from other neuroses. Moreover, out-patient treatment may often be insufficient, and a residence in a special hospital will often be of the utmost value as a preliminary measure.

So far it has been assumed that the patient has applied for treatment voluntarily or has been persuaded to do so by his friends. Unfortunately many will decline any treatment or refuse to be advised. Others will derive no benefit upon voluntary lines, and some form of compulsory treatment becomes necessary both for their own sakes and that of others.

It will be impossible here to deal with this aspect of the subject in detail; I must only suggest that any new laws relating to inebriety might provide three separate procedures or successive steps in dealing with these patients:

First, a judicial warning, which might be given privately when the justice has satisfied himself that the patient is in danger of alcoholic or drug addiction. This probably would be accompanied by a recommendation to consult a neighbouring clinic, but it would in no way interfere with personal freedom.

Secondly, the appointment of a guardian, who would be legally authorised to stop supplies, and forbid the sale of liquor to the patient, to restrict his liberty within prescribed limits, and to prevent the impoverishment of himself or his family.

Thirdly, internment in a farm colony or other approved home.

It is obvious that such steps could only be taken after independent medical opinion has been obtained, and we cannot complain if the state demands safeguards to prevent any hasty or unjust limitation of freedom. Such safeguards we will welcome if only powers are given to protect the inebriate from himself, and arrest his degradation.

Without fresh legislation, however, it is possible to do much more for persons charged with drunkenness or with offences committed under the influence of drink. Early in this year a report was presented to the Birmingham justices, signed by Mr. Gerald Beesly, the deputy chairman, from which I make a few extracts :

"The minds of many of the Birmingham justices have for a long time been exercised as to the futility and inadequacy of the customary methods of dealing with persons charged with crimes, particularly as to the absence of any consideration of the mental condition of such persons. It has been felt that in many cases some mental instability is the fundamental cause of the commission of the crime, and that 'treatment,' as distinct from 'punishment' (either by fine or imprisonment), is the proper and sane method to adopt. . . ."

"A well-ordered State should clearly make provision for the efficient treatment, and, if possible, cure of those who by their acts or mental weakness are a menace to the community, and thus jeopardise their right to freedom. Hitherto much provision has been made, at enormous expense, for dealing with such persons in their later stages of disability. It is suggested that machinery should be set up which can be put into operation at the early stages."

Among others the following immediately practical methods were advocated :

(1) An expert medical practitioner should be appointed, with whom the justices can confer and take counsel in any particular case. He should attend at the courts from time to time to give evidence when required, and he should interview and report upon cases on remand or adjournment.

(2) The Probation of Offenders Act should be used more widely, and conditions imposed that will ensure the periodic examination of the offender on probation.

It is interesting to note that this report was at once acted upon, and that a medical man with special experience was appointed to assist the justices in dealing with cases of this kind.

Although there are at present no consultation clinics, or farm colonies,

or even proper places of detention for the weak-minded offender, pending a report as to his mental condition, it is gratifying to find that some justices are awake to their responsibilities, and that the scandal of the repeated imprisonment of mental defectives for offences directly due to their deficiency has ceased, at any rate in Birmingham.

I had intended to compare the psychiatry of 120 years ago with that of to-day, but I shrink from the attempt. It would be an easy task to show that progress has been slow and disappointing. No specific treatment of mental disease has been discovered save in the case of that arising from thyroid insufficiency. It is doubtful whether the recovery-rate has improved. Now, as then, patients break down without any assignable cause; now, as then, many recover without our knowing the reason. Making due allowance for altered social circumstances, it is probable that the condition of patients in the more enlightened institutions was not greatly different from that of to-day. In Tuke's description the daily routine so carefully portrayed shows that in the early days of the Retreat the patients received care and attention worthy of our emulation.

The medical literature of that period, moreover, contains much that anticipates modern teaching. In Haslam's observations we find a vivid description of dementia præcox. (24) It certainly is not divided into eight elaborate and confusing subdivisions, but the clinical picture, drawn in fewer and stronger lines, is all the more convincing. Haslam also described general paralysis (25), and his discussion of the hereditary problem, and of the relation of mental and physical factors in ætiology, carries us nearly as far as we can travel to-day. The essential mystery of mental disease baffles us now as it did then.

Still, it would be a mistake to measure the success of medical research by considerations such as these. There is a great deal of unseen work in a building before its walls appear above ground. It is quite unnecessary for me to mention the vast amount of progress made in the anatomy and physiology of the nervous system, in pathology and in biochemistry, and in many departments of science which intimately affect our subject, and which were unheard of a hundred or even twenty-five years ago.

Any attempt to foretell the direction of further progress is quite beyond my powers. It is probable that new clinical methods of examination will be discovered. If, for instance, it became possible to measure degrees of pain, or ascertain with precision the extent to which palsy or some other disability depended upon structural defect, or if we could calculate in advance the breaking-point of mental strain, a new situation would be created.

The war has thrown some light upon one aspect of our subject. We have learnt that symptoms formerly termed hysterical or functional are



not peculiar to the frail or sensitive, but occur in strong men. We find that they continue long after any recognised exciting cause has ceased to operate, and that they frequently disappear suddenly, as if charmed away. Unfortunately we cannot analyse the causes of this recovery, which is ascribed to multifarious agencies: suggestion, hypnotism, psycho-analysis, faith-healing, and sudden emotion, besides ordinary hygienic measures. There is obviously no organic lesion, and though the illness is usually characterised by some manifest physical disability, it is clearly a disorder of the mind rather than of the body. There is urgent need for careful research in order to establish a scientific therapy, so that appropriate treatment can be selected with confidence. Only too frequently such treatment is not forthcoming, and consequently our pension-board rooms are thronged with nervous invalids.

In addition to this, the functional element in definite organic maladies must not be overlooked. Patients with diseases such as disseminated sclerosis and locomotor ataxy frequently present symptoms that bear little relation to the extent of the organic lesion. Even in these cases the disability may in large measure be functional.

Do not these observations throw light on some of the problems of psychiatry, and may we not conclude that sometimes the symptoms of insanity bear little relation to the assigned cause? It seems reasonable, moreover, to assume that such symptoms may continue for long periods of time independently of the original disturbance.

Do not some of our sudden recoveries correspond to the recoveries in the psycho-neuroses? On the other hand, are not some of our chronic cases akin to that of the confirmed neurotic, with this difference, that in the one the disordered function affects intelligence and emotion, and in the other some lower nervous mechanism such as vision or muscular co-ordination?

This thought, of course, does not carry us far; but it suggests that the study of hysterical phenomena may help us greatly. Further, it reminds us to lay due stress on the psychical as well as upon the physical factors in ætiology. The attempt to separate mental and bodily factors must inevitably lead to error, since they constantly react on each other. It is well known that emotional disturbance produces changes in the endocrine organs, and that degeneration of those organs leads to emotional dulness and apathy.

Be this as it may, we have at any rate left behind the doctrine expressed in the dictum, "All insanity is either toxic or traumatic." (26) Just as Tuke and Pinel considered moral treatment of paramount importance in promoting recovery, so we recognise the profound importance of mental strain in the causation and development of certain forms of mental disorder.

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*Goitre and the Psychoses.* By NORMAN ROUTH PHILLIPS, M.D.Brux.,  
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THAT there is some relationship between goitre and the psychoses is beyond all question. We have only to recall the mental syndromes of Graves' disease and endemic cretinism—goitre occurs in all but a few exceptional cases of the former, and in about 50 *per cent.* of the latter. Moreover it is by no means uncommon to find goitre in adult myxœdema.

In this article I propose to show that the rôle played by goitre in the psychoses is more extended than is indicated by the examples just mentioned. I shall also endeavour to explain the nature of this

association of goitre and insanity, and, finally, I shall indicate the lines upon which the treatment of these cases should be based.

Systematic examination of the thyroid demonstrates the fact that enlargement of the gland is of fairly frequent occurrence in asylums, especially in female cases.

It appears, however, that endemic goitre is more often associated with the psychoses than is the sporadic form. Moreover, the enlargement of the thyroid in the former case is much more evident, frequently leading to great disfigurement.

I once had the advantage of visiting the wards of the Bel Air Asylum near Geneva, and I was greatly impressed by the high percentage of patients suffering from goitre—36 *per cent.* for both sexes. The goitrous enlargement had in many of the cases attained to an enormous size.

Various authors have drawn attention to the frequency with which the goitrous become insane; others have remarked on the eccentricities of character and enfeeblement of the intellectual faculties in districts where goitre and cretinism is endemic. In particular I might mention the work of Marzocchi and Antonini. As a result of much careful observation the last-named writers came to the following conclusions:

(1) The goitrous, including congenital cases, are eight times more susceptible to insanity than those not afflicted with thyroid enlargement (*i.e.*, as far as the Province of Bergamo is concerned). Moreover, if one deducts all the congenital cases (cretins, etc.) the goitrous more often become insane than other people.

(2) The curable psychoses do not furnish any difference in the percentage of recoveries, whether the case be goitrous or not.

(3) People not afflicted with goitre, belonging to a district where goitre is endemic, are no more subject to contract mental maladies than those coming from a country where the affection is not prevalent.

Up to a few years ago no satisfactory explanation was forthcoming to account for this association of goitre with the psychoses. It was generally believed that goitre did not affect the thyroid secretion. Within recent years, however, as a result of much clinical, pathological, and experimental investigation, the whole subject of goitre has been revised, and a number of observers have produced evidence to show that the goitrous lesion affects the secreting epithelium in such a way as to cause signs of either hypo- or hyperthyroidism, or the two conditions may exist side by side in the same subject—thyroid instability.

These conclusions are of the utmost importance, as the mere fact of goitre being associated with either thyroid insufficiency or excess places this affection on a footing with the well-known diseases of the thyroid mentioned at the commencement of this article, *viz.*, Graves' disease,

cretinism, and myxœdema, whose relation to the psychoses is an incontestable fact.

It is now possible to divide all the various forms of goitre into two main groups, *viz.*, Group I, those forms which produce hypothyroidism; and Group II, those producing hyperthyroidism.

Group I. Hypothyroidism occurs:

(a) Sometimes as a later stage in parenchymatous goitre, the initial activity of the gland being followed by a phase of secretory exhaustion.

(b) In chronic colloid goitre—as a result of the flattening and atrophy of the epithelial cells from distension of the vesicles with excess of colloid material.

(c) In adenomatous, fibrous, and cystic goitres, probably as a result of mechanical interference with the proper functions of the gland.

(d) Sometimes as a late stage in Graves' disease from fibrous degeneration and atrophy of the epithelium.

Group II. Hyperthyroidism occurs:

(a) In the early stages of parenchymatous goitre as a result of the hypertrophy of the gland which arises in response to a call for increased thyroid secretion.

(b) In Graves' disease where there is active hypertrophy and proliferation of the epithelial cells, with the formation of new vesicles lined with cubical cells and containing colloid.

(c) In a certain proportion of old colloid goitres the atrophied epithelium taking on renewed growth, with the same active cell-proliferation and formation of new vesicles mentioned in the last variety.

Rogers holds the view that "An increase in the size of the gland seems the regular or natural first stage in all acquired thyroid diseases." This opinion is particularly interesting when one takes into consideration the frequency with which pathological changes have been found in the thyroid gland in the insane by many observers.

The frequent association of hypothyroidism with goitre referred to above is worth noting, as the mistake is often made that enlargement of the thyroid gland necessarily points to hyperfunction. Even some of the most prominent observers continue to quote the weight of the gland, implying that if it be above normal hyperthyroidism is indicated and *vice versa*.

*Auto-intoxication.*—Let us consider in more minute detail how the brain may be affected by the goitrous lesion.

The various endocrinic glands, in addition to their specific functions, pour into the blood-plasma certain chemical substances called hormones, which are endowed with the important function of regulating metabolism—one group of hormones exercising an augmentor, the other a



retarding influence. Thus an equilibrium or balance is established, the maintenance of which is essential to health.

We are justified in assuming that a lesion of an important organ, such as the thyroid gland, resulting in diminution or excess of thyroid secretion would produce disorganisation of the delicate harmonic balance and so induce a state of auto-intoxication.

Now, as Lugaro emphasises, the brain is particularly susceptible to the action of poisons, and reacts to those which are produced in the organism itself not less intensely than it does to those derived from outside.

#### INFLUENCE OF THE NERVOUS SYSTEM ON THE THYROID SECRETION.

Increasing interest in this important subject has been manifested of late in consequence of the close relationship which is known to exist between the thyroid gland and the nervous system.

The nerve supply of the gland is derived from the sympathetic system and the vagus. The sympathetic nerves have been proved not only to influence the glandular secretion, but also to regulate and control the delicate inter-relationships existing between the various endocrinic glands.

The influence of the higher nerve centres on the thyroid secretion is shown by the fact that emotional states—*e.g.*, fear, anger, anxiety—are capable of producing states of hyperthyroidism.

The following statistics are interesting as showing the frequent association of endemic goitre with the psychoses:

Of 291 patients examined by Brissard at the Bel Air Asylum, Geneva, 106 were found to be goitrous (44 males and 62 females, or 36 *per cent.* for both sexes). These figures are remarkable when compared with the statistics furnished by the Recruiting Office for the Canton, the proportion of goitrous as indicated by the latter being only 5 *per cent.* The 106 goitrous patients included 71 cases of dementia præcox, 18 cases congenitally weak-minded, 8 cases of senile dementia, and 4 of manic-depressive insanity. The frequency of goitre in dementia præcox and in congenital idiocy is significant. Out of a total number of 149 cases of dementia præcox 71 were goitrous, *i.e.*, 49 *per cent.*, and out of a total of 37 cases of congenital idiocy 18 were goitrous, *i.e.*, 48 *per cent.* Hardly less interesting are the statistics drawn up by Schranz at the Hall Asylum in the Tyrol, and quoted by Brissard.

Of 277 patients under observation Schranz found 68 goitrous, *i.e.*, 24.5 *per cent.*, as compared with 15 *per cent.* for the rest of the population. These 68 goitrous patients included 45 cases of dementia præcox, 13 of mania, 7 of congenital idiocy, and 3 of epilepsy. The large proportion of cases of dementia præcox is again worthy of note.

## CLINICAL CASES.

A word is necessary to explain why I have included cases presenting exophthalmos (*i.e.*, cases of Graves' disease) in the following table. Experience has shown me that all cases of goitre, both of the "simple" and of the "exophthalmic" type, are liable to undergo changes, not only in the size and shape of the thyroid gland, but also in the signs and symptoms by which they are accompanied (whether these latter be of a somatic or mental character).

Thus a case of apparently simple goitre may sooner or later develop all or many of the signs indicative of Graves' disease, *e.g.*, exophthalmos, tremors, palpitation, etc., as well as the mental instability so characteristic of that disease; a case of Graves' disease, too, is liable to undergo changes, *e.g.*, the exophthalmos, tremors, palpitation, etc., may disappear—so that if one were not acquainted with the history of the case one might be tempted to make a diagnosis of "simple goitre."

The following table summarises the observations made by me on twenty-four insane patients who were affected with goitre. Two hundred patients were examined at St. Andrew's Hospital, Northampton, so that the actual proportion of goitrous was 12 *per cent.*

No. of case.	Psychosis.	Lobes affected.	Pulse rate.	Systolic blood-pressure.	Exophthalmos.
1	Melancholia . . . . .	M + R	96	148	S
2	Paranoia . . . . .	R + L	72	118	—
3	Dementia præcox . . . . .	L	60	120	—
4	Senile melancholia . . . . .	R	80	176	—
5	Mania . . . . .	R + L	70-120	150	—
6	Manic-depressive . . . . .	M	72	140	—
7	Melancholia . . . . .	M	84	140	—
8	Manic-depressive . . . . .	R	0	0	—
9	Mania . . . . .	G	64	192	—
10	Manic-depressive . . . . .	R + L	88	130	—
11	Paranoia . . . . .	R + M	0	0	—
12	Dementia præcox . . . . .	L + R	80	142	—
13	Dementia præcox . . . . .	M	88	130	—
14	Mania . . . . .	R + M	76	120	S
15	Dementia præcox . . . . .	G	84	160	—
16	Manic-depressive . . . . .	R	0	0	+
17	Involucional melancholia . . . . .	R + L	0	0	+
18	Manic-depressive . . . . .	R + L	120	190	+
19	Melancholia . . . . .	R + M	72	112	—
20	Manic-depressive . . . . .	M + R	74	138	—
21	Mania . . . . .	M	90	160	—
22	Paranoia . . . . .	G	88	140	—
23	Melancholia . . . . .	R + L	98	166	+
24	Melancholia . . . . .	L	92	142	+

*Explanation of abbreviations.*—M = Middle lobe. R = Right lobe. L = Left lobe. G = General enlargement of the thyroid gland. S = Slight. + = Present — = Not present. 0 = Not obtained.

It will be seen that out of 24 cases of goitre under observation no less than 17 suffered from manic-depressive insanity or from the melancholia of involution, *i. e.*, 70 per cent. of the whole number. Of the remaining 7, 4 were cases of dementia præcox, and 3 of paranoia.

CASE 5.—Æt. 47, was admitted October, 1912.

*Family history.*—Father insane—chronic melancholia.

*Physical examination.*—Slight enlargement of the thyroid; exophthalmos; palpitation; pulse-rate 100; some emaciation; poor general health.

*Mental.*—She was restless, talkative, memory defective, attention distractible, emotional, irritable, apprehensive. She was lacking in concentration; complained of headache and noises in the head; troubled with insomnia, frequently asking for drugs.

January, 1913, she was discharged.

September 22nd, she was again admitted, suffering from mania. She had been over-indulging in drugs and alcohol. The physical and mental symptoms were similar to those mentioned above.

October 19th, 1914: Transferred elsewhere.

November 1st, 1915: Readmitted into this Hospital suffering from chronic mania.

*Present state: Physical.*—There is slight general enlargement of the thyroid, frequent attacks of tachycardia, pulse varies between 70–120, systolic blood-pressure 150, fine tremors of the hands, moisture of the skin, slight exophthalmos.

*Mental.*—She is very emotional, with frequently changing moods; she is irritable and at times noisy and abusive; occasionally she is violent to the nurses; she is very verbose with flight of ideas; attention is distractible; she writes endless illegible nonsense on scraps of paper and leaves torn out of books; she is very restless; memory is impaired; she is untidy and fantastic in dress; she is apprehensive with delusions of persecution.

This case may be considered a typical one of hyperthyroidism with characteristic mental symptoms. It will be noticed that all the psychic processes are affected, but it is the emotional sphere which is most profoundly disturbed, and which seems to dominate the whole personality. It is interesting to note that the thyroid gland has been styled by Léopold Lévi, “La Glande d’emotion.”

The frequent occurrence of mania, melancholia, and manic-depressive insanity in Graves’ disease led Parhon and others to think that exaggeration or perversion of the function of the thyroid gland plays an important rôle in the production of these psychoses as a rule, and pathological research has tended to confirm this view, but Parhon admits that hypothyroidism sometimes favours the development of melancholia.

The mental state of CASE 21 resembles in many ways the above. In addition, however, to the irritability, distractibility, restlessness, etc., she has auditory hallucinations and many changing delusions.

This patient has a large goitre about the size of more than half a

croquet-ball involving chiefly the middle lobe of the thyroid, the lateral lobes being also slightly involved. This goitre occasionally increases in size and is liable to cause some embarrassment to breathing, and some cyanosis due to pressure. There are periods when the cardio-vascular signs are accentuated—tachycardia, with a pulse-rate of 120 or more, and fine tremors of the fingers; there is no exophthalmos.

The family history is interesting, three sisters having goitre.

CASE 14 is chiefly interesting on account of the family history. She suffered from chronic mania with secondary dementia. There is a large goitre involving the isthmus and right lobe of the thyroid which has existed since childhood. (She is now 62.)

*Family history.*—One sister had goitre, and was also mentally deficient and died of diabetes. Another sister had goitre.

CASE 19.—Æt. 33. Admitted November 7th, 1917.

*Family history.*—One sister has a larger goitre. Maternal aunt (Case 17) goitrous. Mother died in an asylum.

Patient has a goitre of the shape and size of half a hen's egg, the long axis almost vertical, involving right lobe and isthmus.

She is suffering from melancholic stupor. There is a history of coitus interruptus.

CASE 1.—Æt. 43. Single. Admitted August 11th, 1917.

*Family history.*—Father, paternal grandfather, one brother and one sister goitrous. There is also a history of neuroses in family.

*Previous history.*—Since the commencement of menstruation (æt. 17) she has made repeated attempts to earn a living by teaching, etc. These endeavours invariably sooner or later led to a physical and nervous breakdown, with the following symptoms: "Violent throbbings in the neck and stomach," retching, vomiting, and dizziness, all accentuated by exertion. She was at the same time troubled with insomnia, was depressed and apprehensive. Six weeks previous to admission she developed delusions of hypnotic influence. An attempt to take her life by drowning resulted in certification.

*State on admission: Physical.*—Above average height; fairly nourished; fairly large goitre of the middle and right lobes. Heart, systolic murmur at apex; palpitation at times; slight exophthalmos.

*Mental.*—She was suffering from melancholia of the anxious type; emotional and agitated; delusion that she was hypnotised by an atheist; that in consequence she was possessed of the devil, her soul lost, and she was unworthy to live; auditory hallucinations; insomnia troublesome.

Later she became stuporose.

December 18th, 1917: Taken out by her father.

January 1st, 1918: Returned to this hospital in much the same state, physically and mentally, as on previous admission.

*Progress of case.*—The goitre remained prominent; she complained of throbbings in the neck and palpitation at times; easily tired. She was anxious and apprehensive, and dreaded the thought that the restlessness and insomnia might return; fleeting delusions.

A change to our sea-side home in the summer had a beneficial effect. She became more sociable and did some useful household work.



December 3rd, 1918: She improved sufficiently to return home, and she has maintained her improvement for six months.

CASE 6 is a typical case of "folie circulaire" of many years standing. Periods of depression are followed by periods of exaltation and restlessness, which in turn give place to intervals of comparative lucidity.

There is a goitre about the size of a walnut involving the thyroid isthmus.

*Heredity.*—Two brothers insane.

CASE 20.—Æt. 59. Admitted December 17th, 1917.

*Family history.*—Father, paternal aunt, and sister all had goitre. Husband developed goitre shortly after his wife's admission to this hospital.

*Previous history.*—She had had frequent attacks of depression, alternating with periods of mania, when she quite lost control of herself.

*State on admission: Physical.*—Goitre about the size of a small tangerine orange chiefly affecting the isthmus, but right lobe also involved. Pulse 98; heart irregular at times; systolic blood-pressure 138.

*Mental.*—Periods of excitement, when she was noisy, restless, impulsive, and violent, alternating with periods of depression, apprehension, and delusions of unworthiness and of culpability—she believed she would have to suffer torment and be killed. Under the influence of these ideas she had an uncontrollable impulse to scream loudly.

July 11th, 1918: She was discharged recovered after a visit to the sea.

It seems probable that the variety in the psychic syndromes which occurs in the recurrent, alternating, and circular types of insanity may be brought about by changes taking place in the enlarged thyroid gland, resulting in the association in the same subject of hyper- and hypothyroidism.

It may be convenient at this stage to compare the psychic syndrome of typical hyperthyroidism as seen in Graves' disease with the mental symptoms of typical hypothyroidism as seen in the myxœdema of adults. The acceleration of the mental processes in the former is in marked contrast with the retardation which obtains in the latter.

*Perception* is impaired in Graves' disease, and hallucinations are frequent.

*Memory* is impaired both in myxœdema and in Graves' disease.

*Attention* is difficult to obtain in myxœdema, whereas it is easy to obtain but difficult to fix in Graves' disease.

*Association of ideas* is very slow in myxœdema, whilst it is rapid in Graves' disease owing to the distractibility of attention.

*Emotions.*—The myxœdematous is dull and indifferent. In Graves' disease there is instability, irritability, and extreme irascibility.

*Capacity for mental work* is much impaired in myxœdema as a result of apathy and indifference. In Graves' disease the distractibility of

attention prevents concentration and perseverance—qualities which are essential to the performance of mental work.

*The reactions* are rapid in Graves' disease, whilst in myxœdema they are sluggish.

*Sleep*.—In myxœdema there is somnolence. In Graves' disease there is insomnia.

CASE 12.—Æt. 33. Dementia præcox. Admitted January, 1904.

*Previous history*.—She had been weak-minded for years.

On admission she was dull and listless, unoccupied and untidy.

*Progress*.—On one occasion she expressed her intention to commit suicide, but never attempted to do so. Occasionally she would mutter to herself. At times she was restless. The mental processes have gradually deteriorated.

*Physical state*.—There is a goitre affecting both lateral lobes of the thyroid—more marked on the left side. She has many of the stigmata of hypothyroidism—*e.g.*, stature small with poor development of the limbs, teeth deficient and defective, eyelashes scarce and blepharitis, disappearance of the outer third of eyebrows, shivering fits, temperature subnormal, cold extremities with cyanosis and chilblains, pulse small, 76, œdema of feet, easily fatigued. There is marked ichthyosis, the skin over the whole of the body being dry, with copious shedding of epidermic scales daily from the face and feet.

*Mental state*.—Expression vacant, she is listless and apathetic, and will sit in one position for hours gazing vacantly on the floor; attention is difficult to obtain and to fix; she has no regard for herself, her personal appearance, or her future; she is unoccupied, occasionally mutters to herself, association is sluggish—she never speaks on her own initiative, showing some incoherence and defective memory; movements catatonic in type.

This case is remarkable for the number of signs presented which indicate thyroid insufficiency. Several observers have drawn attention to the association of ichthyosis with this condition. Hertoghe has mentioned the occurrence of blepharitis.

The small stature and poor development of the limbs suggest that the trouble began in early adolescence, and this view is supported by the history of the case, which shows that the patient had been weak-minded for many years previous to admission.

Confirmation of the subthyroidic origin of the syndrome is furnished by the decided amelioration which results from the exhibition of thyroid extract in her case. Thus within three weeks of starting the treatment the ichthyosis and the general physical health had considerably improved, and there was also a remarkable change for the better in the mental state—the expression became more intelligent; attention was readily obtained and held; association was improved. The patient thanked me very much for ordering the tabloids, and said she woke in the morning feeling much refreshed and clearer in the head since taking them; she implored me to let her go on with the treatment. Besides

displaying more initiative in conversation her memory was improved, and she recalled without effort various events which had happened in the past.

CASE 13.—Dementia præcox, also shows some of the signs of subthyroidism, *e.g.*, small stature and poor development, the eyebrows are sparse in the outer third ("eyebrow sign"), eyes deep-set, small and lacking in expression, anorexia is a marked symptom.

CASE 15.—Dementia præcox, presents the eyebrow sign, coldness of the extremities, and a tendency to chilblains.

CASE 3.—Dementia præcox, shows the eyebrow sign, pulse 60 and small.

It is thus seen that all the four cases of dementia præcox included in the above table present, in a greater or less degree, stigmata of thyroid insufficiency.

In order to explain the association of goitre with dementia præcox as well as with congenital cases which was so striking in the statistics of Brissard and Schranz, it is necessary to consider the facts.

The thyroid gland not only governs the building up of the cells of the organism, including those of the central nervous system, but it also regulates their development.

In consequence of this there is an increased demand for thyroid secretion in infancy, early childhood, puberty, and adolescence. Owing, however, to the goitrous lesion the thyroid gland is naturally hampered in its endeavour to meet this demand. Should the weakened gland give way under the strain and its secretion become exhausted, disorganisation with auto-intoxication will result.

Now if this disorganisation occurs in infancy or early childhood it may conceivably give rise to imbecility, or even idiocy. On the other hand, if it be delayed to adolescence dementia præcox may result.

I have obtained a family history of goitre in three cases of dementia præcox, only one of whom presents some fulness of the neck, the other two show no thyroid enlargement at the present time :

The first is a male whose mother has a large goitre, and a maternal cousin has exophthalmic goitre ; in the second (male) the father and paternal uncle both suffer from goitre with exophthalmos. The third is a female whose paternal aunt has exophthalmic goitre.

In Case 2 (paranoia) the goitre is probably secondary to tuberculous disease of the spine with psoas abscess. There are signs pointing to hypothyroidism—scarcity of eyebrows, with chilliness and subnormal temperature.

The remaining two cases of paranoia are so suspicious and deluded that fuller examination is impracticable at present.

A study of the foregoing cases emphasises the great importance of heredity as an ætiological factor in thyroid abnormalities.

There are certain points of difference in the results of my observa-

tions as compared with those of Brissard and Schranz which need some explanation.

I have pointed out that the majority (70 *per cent.*) of my cases were manic-depressive or involutional melancholiacs, and a minority (16.6 *per cent.*) were cases of dementia præcox.

On the other hand, Brissard and Schranz both found that the majority of their cases belonged to dementia præcox and congenital idiocy groups, the number of cases of manic-depressive insanity being comparatively small.

In my opinion, this disparity can be accounted for by the fact that sporadic goitre is more often accompanied by hyperthyroidism, and that this latter condition plays an important rôle in the production of manic-depressive insanity.

On the contrary, there is reason to believe that endemic goitre is associated with hypo-thyroidism, which condition appears to favour the onset of congenital idiocy and dementia præcox.

The absence of cases of congenital idiocy from the above table is due to the fact that such cases are not received into St. Andrew's Hospital.

*Ætiology of goitre.*—Before discussing the question of treatment it is essential to give a brief description of the ætiology of goitre.

Heredity is a most important factor, as will be seen by a reference to the cases I have described above. In many of these I have found a family history not only of goitre but of neuroses or psychoses.

Persons of an emotional or neurotic temperament are particularly prone to develop goitre.

Women are much more liable to this affection than men.

There are various circumstances and conditions which impose an extra strain on the thyroid gland, and may determine its enlargement. Thus a goitre may develop as a result of emotional states, *e.g.*, fear, anger, anxiety, etc., prolonged mental or physical stress, hygienic errors, deficient or improper food, puberty, menstruation, pregnancy, or sexual excess.

Enlargement of the thyroid gland in young girls has been particularly noticeable during the recent great European war—emotional and physical stress and the poorer standard of food probably acting as contributory factors.

Since the beginning of the war attention has been repeatedly drawn to the occurrence of goitre accompanied by symptoms of hyperthyroidism in men from 20 to 45 years of age. I have met cases of this kind who have been diagnosed "D.A.H."! The cause is said to be chiefly emotional exhaustion, and in a lesser degree physical exhaustion.

A number of diseases and toxæmias are capable of causing hyper-



plasia of the thyroid gland, *e.g.*, rheumatic fever, measles, scarlet fever, pyorrhœa, tuberculosis, etc.

All these toxæmic conditions tend to weaken the secretory value of the thyroid gland, and may result in thyroid insufficiency.

Endemic goitre is supposed to be produced by a chronic toxæmia.

Pathological examination in the majority of cases of endemic goitre shows the thyroid gland to be in a state of colloid or fibrous degeneration which, we have seen, results in hypothyroidism.

#### TREATMENT.

In the ætiology of the psychoses associated with goitre it is important to realise that there are often two factors, a physical and a mental.

In the treatment of these psychoses the physical element should be dealt with before any special mental therapy is undertaken.

*Physical treatment.*—The importance of an early recognition of the somatic signs indicative of hypo- or hyperthyroidism cannot be too strongly emphasised.

*Hypothyroidism.*—If the physical signs point to this condition thyroid therapy should be at once commenced, and the greater the number of stigmata present the better the chance of success from this remedy. Quite small doses as a rule produce the best therapeutic effect. The pulse and weight must be carefully watched, and if any sign of hyperthyroidism appear the treatment should be suspended for a while. In any case it is well to suspend the drug for a few days about every tenth day and always during menstruation.

The treatment may have to be continued for years, and sometimes for a lifetime.

It is essential in every case of goitre to look for any possible source of toxic absorption; thus attention should be directed to the condition of the mouth, the state of the bowels; the diet should be regulated, any tubercular focus should be efficiently dealt with.

Where insufficiency of the other endocrinic glands is suspected suitable glandular extracts may be added to the treatment, but not before a thorough trial has been made with thyroid therapy alone.

The results of this treatment are often gratifying, not only from a physical point of view, but the mental symptoms may also be much ameliorated and cures may result.

*Hyperthyroidism.*—Although an extraordinary number of drugs have been tried in this condition, not one can lay claim to having a specific action. It should be mentioned, however, that calcium lactate (gr. 10 three times a day) has been used with some success, both in Graves' disease as well as in states of excitement.

Organotherapy has been employed, but hitherto without success; it would seem that our knowledge of the complicated interactions between the various endocrine glands is as yet but imperfectly understood.

X-rays, surgical operations, and various other physical agents have their advocates, but in many cases they are not only useless but positively harmful.

*Mental treatment.*—Psychotherapy has recently been recommended in cases of Graves' disease, and there are three reasons which would seem to justify its employment in all cases of hyperthyroidism, *viz.* :

(1) The undoubted importance of the mental element (whether this be primary or secondary) in the ætiology of these cases.

(2) The predominance of nervous and mental symptoms in exophthalmic goitre.

(3) The failure of all other therapeutic measures (drugs and physical agents) to deal effectively with these cases.

Moreover, psychotherapy might usefully be employed in those cases of hypothyroidism in which thyroid treatment has proved inadequate in the removal of the mental symptoms.

There are two methods of applying psychotherapy, *viz.* (a) suggestion, and (b) the exploration of underlying mental conditions.

Psychotherapy has already been used with some success in certain cases of dementia præcox, of paranoia, and of manic-depressive insanity.

In the other psychoses this method of treatment is still in the embryonic stage, but, if one may judge by the progress made in the past, there is every reason to look forward to still further extensions of its applicability.

#### SUMMARY.

(1) We have seen the frequency with which goitre is associated with the psychoses—in a mental hospital receiving no cases of idiocy, one patient in every eight having some thyroid enlargement.

(2) As to the mechanism of this association we have seen that (a), goitre is, at some time in the patient's history, accompanied by a condition of hypo- or hyperthyroidism, and that (b) either of these conditions is capable of inducing a state of auto-intoxication with mental symptoms.

(3) My series of cases show that the nature of the psychosis is, in some degree, determined by the form of the functional disturbance of the thyroid gland, *e. g.*, hyperthyroidism is usually associated with states of excitement, agitation, etc. (*e. g.*, manic-depressive insanity), whereas hypothyroidism is more often associated with states of apathy and indifference (*e. g.*, dementia præcox).

(4) The treatment of the psychoses associated with goitre depends to some extent on the nature of the functional disturbance of the thyroid gland. If the signs point to hypothyroidism treatment by thyroid extract should be instituted. If hyperthyroidism is present the treatment should be directed to the removal of the mental element, which is now admitted to be of great importance in the ætiology of this condition. The only satisfactory method of accomplishing this is by the employment of psychotherapy.

My thanks are due to Dr. D. F. Rambaut, Medical Superintendent of St. Andrew's Hospital, for permission to publish the above cases, and for valuable suggestions; also to Professor Weber, Médecin Directeur of the Bel Air Asylum, Geneva, for the kind interest he has taken in my essay.

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*On the Cytology of the Cerebro-spinal Fluid in Mental Disease.*

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## INTRODUCTION.

THE fluid obtained by the easy and now frequent procedure of lumbar puncture affords, when subjected to simple tests, valuable aid in the diagnosis of mental disease.

These simple tests served the purpose of the clinician whose main object was to make a rapid diagnosis, yet it was felt that improvements in method and technique were desirable so that advance could be made in the field of cell differentiation.

Advance was rendered possible by the introduction by Alzheimer (1) of a method whereby the cerebro-spinal fluid could be treated along the lines employed in the histopathology of the central nervous system.

This method has been adopted on the Continent and in America, but as far as I am aware there have been only two papers published in this country—one by the American authors, Cotton and Ayer (2), and one by Henderson and Muirhead (3). By means of it the various types of cells are fixed and stained in a manner essentially similar to those of the tissues. The types of cells present in the fluid and the brain can be compared in a way that has never hitherto been possible. In this method the cells are fixed by adding 96 *per cent.* alcohol to the cerebro-spinal fluid, which precipitates the proteid, and by centrifugalisation are drawn down with the proteid in the form of a coagulum to the bottom of the tube.

Alzheimer's technique has been followed in this research, and this paper incorporates the results from an examination of the cerebro-spinal fluid in 100 cases of mental disease.

In detail the method of Alzheimer as used is as follows:

- (1) Lumbar puncture in the usual manner.
- (2) Ninety-six *per cent.* alcohol is added drop by drop and well mixed—10 c.c. alcohol to 5 c.c. cerebro-spinal fluid.
- (3) Centrifuge the mixture for half an hour at a high speed in a glass tube with a conical end. Tube well stoppered to avoid evaporation.
- (4) The supernatant fluid is poured off, leaving a small coagulum in the bottom of the tube.
- (5) Add absolute alcohol—alcohol and ether—each separately for one hour to dehydrate and harden coagulum.
- (6) The coagulum is removed from the bottom of the tube by tapping and allowed to drop into thin celloidin, where it remains for twelve hours.



- (7) Coagulum placed in thick celloidin for twelve hours.
- (8) Mounted on blocks, hardened in chloroform for half an hour, and cut at  $8\ \mu$  on a Jung microtome.
- (9) Section stained.

#### PROCEDURE.

(1) Sections placed in absolute alcohol for a minute and spread out on a cover-glass; as many as eight sections can be accommodated on one cover-glass.

(2) Ether vapour is poured over the cover-glass; by this means the celloidin is removed and the section is fixed to the cover-glass.

(3) Section is hardened by placing in methylated spirit.

(4) Place section in water.

(5) Stain as follows: Pappenheim's pyronin-methyl green (Grübler). The sections are placed in this stain for five to seven minutes in an incubator kept at  $37^{\circ}\text{C}$ . The sections are then washed in water, differentiated in absolute alcohol, cleared in Bergamot oil and mounted in balsam.

Other stains used were Unna's polychrome blue, Nissl's methylene blue and toluidin blue.

The pyronin-methyl green gives excellent nuclear pictures, a slight pink tint to the protoplasm in most cells, and is considered specific for plasma-cells.

The fluid must be centrifugalised long enough to give a firm coagulum, yet not too long, otherwise the cells are driven to the apex of the coagulum. I found by experiment that to have the cells evenly distributed throughout the coagulum centrifugalisation for half an hour at 2,000 revolutions per minute proved satisfactory.

The central portion of the coagulum was cut in vertical sections

#### DIFFERENTIATION OF CELLS.

Hitherto the diagnosis of general paralysis by the examination of the cells of the cerebro-spinal fluid has depended entirely on the enumeration of those cells, and the determination of whether a lymphocytosis is present or not. Recently, however, it has come to be recognised that a study of the various types of cell is of equal importance.

It was generally recognised that the presence of plasma-cells was as characteristic of general paralysis as a lymphocytosis, but this type of cell is common in many chronic inflammations. That plasma-cells occur in the cerebral cortex and pia mater in general paralysis is a well-known fact, but until Alzheimer's method had been introduced they had never been found in the cerebro-spinal fluid. Indeed, Nissl was led to doubt the pial origin of any of the cerebro-spinal cells because

of the absence of these in the fluid in cases which showed abundance of them in the pia and cerebral cortex.

The description of the cell-types closely follows that of Cotton and Ayer, as the appearances in my sections have been in agreement with their findings in fluid withdrawn during life.

In the normal cerebro-spinal fluid one has practically only one type of cell to consider, namely, the lymphocyte.

It is doubtful whether the polymorphonuclear leucocyte can enter the fluid during health, and its presence always indicates the existence of some irritative process. As a rule this is acute, and the condition in which the greatest polymorphonuclear leucocytosis occurs is acute suppurative meningitis. This cell is, however, also found in the chronic inflammatory conditions, of which the best example is general paralysis.

In general paralysis and tabes dorsalis several other varieties of cells occur, and in these diseases the cells were sufficiently numerous for a fair differential count to be made. A differential count was made in cases in which at least 200 cells could be distinguished. In some cases this necessitated a search through six to eight sections. The percentage cell-counts will be found in Table I. In conditions in which the cells were too scarce for differential purposes the existence of each type of cell encountered has been denoted in Table II.

The following is a brief description of the various types of cells :

#### LYMPHOCYTES.

Lymphocytes are found in all fluids, but apart from fluids of parasymphilitic conditions they occur in very small numbers.

The nucleus is small and round, sometimes oval and slightly indented, and contains as a rule a single, bright red nucleolus. The chromophilic granules lie round the periphery, giving a clock-face appearance, and take on a deep, blue-green stain with Pappenheim's stain.

The protoplasm is found as a thin line round the nucleus, stains a faint pink, and it is usually a little wider on the indented side of the nucleus.

Lymphocytes show altered and transitional forms. The nucleus is similar, but there is an increase in the protoplasm. Occasionally the nucleus takes on a deeper stain. Another type of lymphocyte, classed as the large, is one in which the nucleus, with its granules, is much increased in size, and has a thin ring of protoplasm around it.

In general paralysis the differential count shows that the lymphocytes are the principal cells increased, varying from 39 to 78 *per cent.*, the transitional forms ranging from 2 to 19 *per cent.* Including all types of lymphocytes together in one class the average in general paralysis is 71 *per cent.* The total cell-count in general paralysis averages from 458 to 100 fields.

## POLYMORPHONUCLEAR LEUCOCYTES.

Polymorphonuclear leucocytes were present in 15 out of the 17 cases of general paralysis, and in only 6 of the remaining cases of insanity.

Case 12 is worthy of note, as the leucocyte count reached the high figure of 29 *per cent.* Blood contamination could be fairly excluded in the cases both by the clearness of the centrifuge deposit, and the absence of red blood-corpuscles in the Widal film from the same fluid as the Alzheimer. Further, the withdrawal of the fluid had no relation in point of time with any seizure or expected seizure, or change in the patient's physical or mental state.

With the pyronin-methyl green stain the nuclei only are stained, no protoplasm is visible, and the cells are distinctive.

## PLASMA-CELLS.

These cells are comparable to that of a lymphocyte with its protoplasm greatly increased in amount.

The nucleus is about the size of that of a lymphocyte, but the chromatin granules are more distinct, take on a deeper blue-green stain, and there is a bright red nucleolus. The protoplasm is two or three times the size of the nucleus, takes on a deep red pyronin stain, and occasionally has a lighter area round the nucleus. The nucleus is always placed eccentrically in this deep-red protoplasm. Double nuclei are not uncommon. The protoplasm is of oval outline, and in only a few cells could the protoplasm be described as polygonal. This description corresponds with the plasma-cells as originally described by Waldeyer and Unna (4). In well-stained sections the plasma-cells are distinctive and of easy differentiation.

Plasma-cells were found in 16 out of 17 cases of general paralysis, the average being 2 *per cent.*, in 2 cases of tabes dorsalis, the average being 2 *per cent.*, and in 1 case of a congenital syphilitic idiot boy.

## ENDOTHELIAL CELLS.

These cells were always present in my series of cases. They vary considerably in size and shape, and are the largest cells found in the fluid.

The nucleus is, as a rule, kidney-shaped, sometimes oval, and is usually lying at the periphery of the cell.

The nucleus stains a faint blue-green with pyronin-methyl green stain, contains few chromatin granules, and has from one to three bright red nucleoli. The protoplasm stains a faint pink, and shows marked variation in amount even in the same fluid.

There is a distinct form of endothelial cell, designated as "Gitter" cell by Rehm (7), in which the protoplasm presents a fenestrated or latticed appearance. These clear areas suggest that these cells are of a phagocytic character. These latticed cells were found in 15 out of 22 cases of general paralysis, in 3 cases of epilepsy, in 2 cases of melancholia, and in one case each of the following: tabes dorsalis, imbecility and idiocy.

The average endothelial cell-count in general paralysis was 22 *per cent.*, and showed little variation from the average, the highest counts being 43 and 39 *per cent.* in 2 general paralytics who were in a dying condition.

#### PHAGOCYTES.

The most distinctive phagocytic cell encountered was an endothelial cell which had engulfed a lymphocyte.

The endothelial nucleus was horse-shoe-shaped and devoid of chromatin and stained a pale blue.

The lymphocyte nucleus was sharp and the chromatin elements deeply stained a dark blue-green.

The endothelial nucleus occupied one segment at the border of the cell and the lymphocyte nucleus occupied a central position.

The protoplasm of the cell was faintly stained pink except the area round the lymphocyte, which was quite colourless.

This type of phagocyte was found in three of the seventeen cases of general paralysis, but as a rule only nuclear remnants were present in the protoplasm.

A second type of phagocytic endothelial cell was found in comparatively large numbers (9 *per cent.*) in the fluid of case No. 5. At the time of withdrawal the fluid was found to be tinged yellowish-red, and the colour remained even after centrifuging, thus proving that the colour was due to blood originally present in the fluid, and not to contamination at the time of puncture. Further, no red blood-corpuscles were found in the Widal film.

The cells were endothelial in type, as they contained eccentric oval nuclei, and a large amount of protoplasm. In the protoplasm could be seen fine yellowish granules occupying the greater part of the cell protoplasm, and these were considered to be composed of altered blood-pigment.

The clinical history of the case is of interest. The man was an excited general paralytic, who had a slight seizure on February 26th, 1913, followed by a severe seizure on March 2nd, which left him with a right-sided hemiplegia. Lumbar puncture was performed on March 11th. The patient died on March 17th, and the *post-mortem* examination revealed an extensive meningeal hæmorrhage over the left motor area.



It can fairly be considered, therefore, that the endothelial cells of the cerebro-spinal fluid were acting as phagocytes for the blood-pigment derived from the hæmorrhage.

#### MITOTIC CELLS.

Only two cells showing mitotic figures were encountered, and these were found in sections of two different general paralytic fluids. Both cells showed well-marked mitotic figures, and one appeared to be undergoing subdivision.

#### UNCLASSIFIED CELLS.

This class has been necessary, as there are a few cells that could not be included among the types above-mentioned.

#### THE FIBROBLAST.

This cell is distinguished by its spindle-shaped nucleus, which contains faintly stained chromatin filaments, and has apparently only a small amount of protoplasm at the poles of the cell.

#### THE POLYBLAST.

This cell has been described by Wickman (5) and by McIntosh and Turnbull (6) as occurring in the infiltration of the meninges in poliomyelitis, and has not been described, so far as I am aware, as occurring in the cerebro-spinal fluid.

The cell occupies on an average an area equal to that of three red corpuscles, is round in shape, and the nucleus closely resembles that of a polymorphonuclear leucocyte. The nucleus is stained darkly with pyronin methyl-green, with a paler area in the centre which may show a red nucleolus. The protoplasm takes on a fairly red tint with a pinker stain round the nucleus—thus it is distinguished from the polymorphonuclear leucocyte. An occasional cell was found in general paralysis (9 out of 17 cases), in two cases of *tabes dorsalis*, in one case of *dementia præcox*, *idiocy*, and *neurasthenia*.

#### DISCUSSION OF CYTOLOGY.

The main features of interest have already been mentioned under the cell types.

Plasma-cells, phagocytes, and lattice-cells call for a brief discussion.

Plasma-cells were present with one exception in all the general paralytic fluids. The exception was that of a slightly demented patient in whom the disease was slowly progressing.

My findings in *tabes dorsalis* agree with those of Henderson and Muirhead, who found plasma-cells present in two out of three cases of this disease. I also found these cells present in the fluid of a congenital syphilitic idiot, but in no other form of insanity.

TABLE I.—*Showing the Analysis of the Cells in thirty cases.*

No.	Sex.	Diagnosis.	Fluid.	Cells per 100 fields.	Small lympho- cyte.	Transi- tional.	Large lympho- cyte.	Endo- thelial.	Plasma.	Poly- morph.	Phago- cyte.	Unclasi- fied.
1	F.	General paralysis	Clear	414	35	13	21.5	18	5	7	—	.5
2	F.	"	"	400	62.5	10.5	3.5	21.5	1	1	—	—
3	M.	"	"	146	51	19	7.5	19	1.5	2.5	.5	—
4	M.	"	"	676	44	4	28	21.5	—	2.5	—	—
5	M.	"	Yellow	264	50	—	1	39	1	—	9	—
6	F.	"	Clear	340	59.5	10.5	4.5	19	2.5	1.5	1	1.5
7	F.	"	Slightly bloody	221	72.5	2.5	1.5	21	1	.5	—	1
8	M.	"	Clear	530	73.5	6.5	2.5	15	.5	1	—	1
9	M.	"	"	997	68.5	11.5	6.5	7.5	4	.5	—	1.5
10	M.	"	"	460	75	—	1	17	2	5	—	—
11	F.	"	"	880	74	2.5	4.5	17.5	1.5	—	—	—
12	F.	"	"	418	23.5	8	18	19	1	29	—	1.5
13	M.	"	"	177	32.5	14.5	10	33.5	2.5	3.5	—	3.5
14	M.	"	"	722	59.5	7	16	12.5	3.5	1	—	.5
15	M.	"	"	234	31.5	8.5	7.5	43	4.5	2.5	—	2.5
16	M.	"	"	116	71.5	5	2	17.5	3	—	—	1
17	M.	"	"	260	63	9	2	20.5	2.5	2.5	—	2.5
18	M.	Tabes dorsalis	"	87	60.5	4	2	31.5	1	.5	—	.5
19	M.	"	"	398	34	21	6	33	3	—	—	3
20	M.	Acute mania	"	150	73	—	10	16	—	1	—	—
21	M.	Epilepsy	"	168	54	—	5	41	—	—	—	—
22	M.	Delusional insanity	"	70	75	3.5	1.5	20	—	—	—	—
23	M.	Dementia præcox	"	38	50	2	3	41	—	1	—	—
24	M.	Imbecility	"	60	22	6	4	68	—	—	—	—
25	M.	Idiocy (cong. syph.)	"	219	23	16	8	51.5	.5	—	—	1
26	F.	Stupor	"	135	34	16.5	7.5	42	—	—	.5	—
27	M.	Paranoia	"	125	30.5	19	10	40	—	—	—	—
28	M.	Dementia	"	131	19	10	9	62	—	—	—	—
29	M.	Neurasthenia	"	32	57	13.5	1.5	27	—	—	—	1
30	F.	Psychasthenia	"	290	89	—	—	11	—	—	—	—

TABLE II.—*Indicating that Cells were present in the following Thirty-five Conditions, but in such small number that Percentages were valueless.*

No.	Sex.	Diagnosis.	Fluid.	Cells per 100 fields.	Lym-phocyte.	Endo-thelial.	Plasma.	Poly-morph.
31	F.	General paralysis	Clear	—	x	x	x	—
32	M.	" "	"	—	x	x	x	x
33	M.	" "	"	—	x	x	x	—
34	F.	" "	"	—	x	x	x	x
35	F.	" "	"	—	x	x	x	—
36	M.	Mania, mono-	"	—	x	x	—	—
37	F.	" recurrent	"	—	x	x	—	—
38	M.	" "	"	10	x	x	—	—
39	M.	" chronic	"	81	x	x	—	—
40	F.	" "	"	64	x	x	—	—
41	F.	" puerperal	"	13	x	—	—	—
42	M.	" senile	"	—	x	x	—	—
43	F.	Melancholia	"	32	x	x	—	—
44	M.	" "	"	4	x	x	—	—
45	M.	" "	"	30	x	x	—	—
46	F.	" "	"	20	x	x	—	—
47	F.	" "	"	—	x	x	—	—
48	M.	" "	"	56	x	x	—	—
49	M.	" "	"	36	x	x	—	—
50	M.	Epilepsy	"	120	x	x	—	—
51	F.	" "	Slightly bloody	105	x	x	—	x
52	F.	" "	Clear	—	x	x	—	—
53	M.	" "	"	25	x	x	—	—
54	F.	" "	"	28	x	x	—	—
55	M.	Delusional insanity	"	26	x	x	—	—
56	F.	" "	"	21	x	x	—	—
57	F.	Dementia præcox	"	36	x	x	—	—
58	F.	" "	"	74	x	x	—	—
59	F.	" "	"	—	x	x	—	—
60	F.	" "	"	2	x	—	—	—
61	F.	Imbecility	"	14	x	x	—	—
62	M.	Dementia	"	61	x	x	—	—
63	M.	" "	"	29	x	x	—	—
64	M.	" "	"	72	x	x	—	—
65	F.	" "	"	10	x	—	—	—

Plasma-cells cannot, therefore, be considered pathognomonic of general paralysis, but it may be taken that their presence in a case of mental disease is strong evidence of a parasymphilitic lesion.

Phagocytic cells were only found in four cases, namely, three of general paralysis, and one of paranoia (No 27). This latter case is a querulant, impulsive patient, who so far has exhibited no signs of general paralysis. The cerebro-spinal fluid showed no protein increase, but the glycyl-tryptophane test was positive. A moderate lymphocytosis, the indication of a ferment, and the presence of phagocytic cells in the fluid of this case are at least suggestive of some irritative cause.

Lattice cells: Cotton and Ayer describe, under the name of "Körnchen," a type of phagocyte cell filled with numerous fat-droplets or fatty pigment, which they only found in ventricular fluids. Henderson and Muirhead consider these cells to be an early stage of the lattice, and I am inclined to agree with their suggestion.

All endothelial cells, which appear to have a granular or vacuolated protoplasm are included under the one class—lattice.

As before mentioned, these cells were found in a number of conditions, and I cannot substantiate the view taken by Henderson and Muirhead, who considered that the absence of lattice cells in their cases of *tabes dorsalis* might be a point of value in the differential diagnosis between general paralysis and *tabes*.

#### CONCLUSIONS.

Examination of the cerebro-spinal fluid is of great importance and a valuable aid in the diagnosis of mental disease.

Alzheimer's method is the best for the cytological examination of the cerebro-spinal fluid: cells can be differentiated in a way never hitherto possible, and a fair quantitative count can be made.

The cells of the greatest diagnostic importance are the plasma-cell, the phagocytic and endothelial cell, and the lymphocyte in excess.

A high cell-count with an excess of lymphocytes together with the presence of plasma-cells is strong evidence of parasymphilitic lesion.

Rest in bed after lumbar puncture is desirable to avert the after-effects.

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### Clinical Notes and Cases.

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*Notes on a Case Treated by Hypnotic Suggestion.*<sup>(1)</sup> By  
G. RUTHERFORD JEFFREY, M.D., F.R.C.P.E., F.R.S.E.

MR. PRESIDENT AND GENTLEMEN,—You will, I know, agree with me that there is no doctor who has not frequently been at a loss to know what treatment to adopt in a case which, although apparently simple and straightforward, continued to show no signs of improvement, and when we are dealing with mental cases this is, I think, especially noticeable. But, after all, we must admit that the means at our disposal for the treatment of mental diseases are very inadequate—differing widely from many medical and surgical conditions in which the only and proper treatment is invariably followed by recovery. In most mental diseases I am afraid we must acknowledge that there is still no specific treatment guaranteed to cure any given case: recoveries frequently occur when least we expect them, cases which we deem recoverable frequently disappoint us.

I feel justified, therefore, in bringing the following case to your notice as illustrating a method of treatment which, at least, should not be lost sight of in dealing with cases which are presumably, shall I say, hopelessly mental, and in connection with this case I am raising the question of treatment by hypnosis and suggestion.

This form of treatment is at present giving rise to much discussion. We all know, I think, how much suggestion, with or without hypnosis, has been used during the recent war, when dealing with cases of shell-shock, neurasthenia, hysteria, and cases showing a variety of symptoms common to each of these conditions. Hypnosis has been used in order to produce sleep; I have seen it used, and have used it myself with excellent results. Along with suggestion it has been used to cure many conditions, and by making the patient, as it were, live through his experience again, and thereby reinstating the emotion of fear, mutism, amnesias, stammering, tremors and hysterical contractures have been successfully cured.

Quite recently, in the *British Medical Journal* (?), there appeared a short and interesting article on "Hypnosis, Suggestion, and Dissociation," by Dr. William Brown, and with that writer we will, I think, agree when he says that the one satisfactory method of treating the various forms of functional nervous disorders is that of mental analysis and re-education, and he suggests the term "autognosis" or self-knowledge, which embraces the two conceptions of analysis and re-education, and is better than the term "psycho-analysis." Dr. Brown goes on to point

out that suggestion with hypnosis is undesirable for the reason that it treats the symptoms and not the cause, and that the patient is passive and abnormally suggestible.

I think it is difficult, however, to draw a sharp distinguishing line between the cause and the symptoms. By mental analysis we may get at the root of the illness, and perhaps find out the cause of the symptoms, and then by re-education the *symptoms* may be, as it were, *made* to disappear.

Whilst this is true, it is equally true that if persistent and distressing *symptoms* can be made to disappear the normal cerebral mechanism has a chance of re-establishing itself, and the person, cured from his illness, may then return to what was his normal. What I mean to suggest is that it is not *always*, in my opinion, necessary before a recovery can be obtained to probe into the hidden depths of a person's life and try to find a "flaw," or attempt to correlate some circumstance in a person's past life-history with present symptoms. There are some who are not contented until they find, or imagine they have found, some circumstance in connection with a person's sexual life, but with these observers I cannot agree. I willingly admit that the sexual influence as part of one's life—for, after all, it is an instinct, mysterious, of great importance, but often latent—is of considerable importance, but I fail to see why what is a perfectly normal part of one's, so to speak, "make up," should be blamed, as it so often is, for producing all kinds of mental states and symptoms.

When we have to deal with an apparently chronic mental case, or at least with one which has for many months shown marked mental symptoms, such a method as treatment by hypnosis with suggestion would, at first sight, appear to offer no hopeful chance of recovery. The following case, however, shows that even a long-standing case can be successfully dealt with, and the result obtained even from this one case certainly justifies the opinion that treatment by this method is always worth consideration.

The case which I bring to your notice is that of a young lady, æt. 20, who came as a voluntary boarder to Bootham Park Hospital. Her hereditary history is unimportant. Up to the commencement of her illness she was in every way normal mentally, although she was of a keen, sensitive, artistic, and highly-strung nature.

About eighteen months before the onset of her illness she was treated for a severe attack of anæmia, and, although she made a good recovery, she was left in a rather reduced state of health.

As in the case of most people, the war had made a marked impression upon her, not only on account of her fiancé's unknown fate—for he was a prisoner of war—but also on account of the terrible sufferings to which our men were exposed, and, as her mother said, the appalling

bloodshed seemed to "get on her nerves." In addition to this she seems to have thought a great deal about the war from a religious point of view, and, like many other people, tried to find out from Biblical comparisons and references if it in any way portrayed the approaching end of the world.

These thoughts caused her to become dull and rather depressed—perhaps quite a natural depression for a person who was so much affected and so much impressed by all the truly terrible circumstances which the war entailed. Suddenly all her symptoms became more pronounced, and, from what I think was an almost natural depression, she passed into a state of profound apathy, with some confusion, intense misery, and at times marked emotionalism, a condition which remained more or less unchanged up to the time of her admission to Bootham Park on April 16th, 1919. Careful investigation of the history in connection with the onset of this marked change for the worse in her condition revealed the fact that it immediately followed on a dream, which was as follows: She dreamt that the sun and moon came into collision, and that, as a result, there was poured out over the whole world a deluge of blood, in which she, along with others, was to be submerged. She awakened in the morning in a state of fear, and felt convinced that she was on the brink of some great catastrophe. She became confused and dazed, depressed and emotional, and, after remaining more or less in this state for a few months, she, of her own accord, sought admission to Bootham Park.

On admission her expression and general demeanour denoted great misery. She looked dazed and terrified, readily admitted that she felt very ill, but on many points her conversation was quite rational. She became very emotional and pleaded with me to make her better, saying that she felt as if she was living in a mist and that she felt detached from everything. Her misery found its outlet in copious weeping, and I was at once struck by the complete absence of any of the usual ideas which are so commonly associated with the true melancholic state—I mean the self-accusations and the melancholic delusions. I felt very strongly—and at that time I had not obtained the true history—that there was something to account for her condition, and, further, even then she appeared to me to be as if in a "dream-state." Her physical condition showed nothing abnormal, but she was much reduced in health and her cardiac action was somewhat feeble. On the evening of the day of her admission I visited her, and endeavoured to get into conversation with her and explain her symptoms. She did not readily converse with me and did not appear to understand all that I was trying to impress upon her. I decided, therefore, to use hypnosis as an aid to suggestion, and in the usual way I put her into a condition of very light sleep. At first, when I was impressing upon her to try

and detach her mind and think of sleep, she became very restless, but this soon disappeared ; she closed her eyes and passed into a condition of absolute calm, which was immediately followed by light sleep. During this state she was able to answer my questions and listen to my suggestions. I explained her condition fully to her, told her that her misery and strange thoughts were all the result of her dream, and impressed upon her that, as she now understood her condition thoroughly, she would in the morning awaken from her sleep feeling better.

I then put her more deeply under hypnosis and left her sleeping. She slept for about five hours and in the morning was calm and composed. She had a quiet day, slept for over eight hours on that night, and in the morning was in every way rational. She at once said that she was better and wished to return home. I urged her to remain here for a short while in order to build up her strength, but as she was determined to leave I communicated with her mother. Her mother visited her and said that she found her perfectly natural in every way—a state which she had not seen her in for about seven months. The mother urged me to allow her to take her home, and finally I consented. She was discharged from here on April 21st, five days after her admission and about seven months after the onset of her illness. I heard from the mother about three weeks ago, and she informed me that her daughter was keeping well, but was still in somewhat poor physical health.

The facts which I have related in connection with this case and the results speak for themselves, and certainly give strong support to the belief that suggestion treatment may be of very great value, and that suggestion may be greatly helped by hypnosis. It is not often that in mental hospitals we meet with cases which can be dealt with in this way, but I am convinced that hypnotic suggestion could in a great many cases be employed with excellent results.

To me this case was one of great interest, and I am pleased to have had this opportunity of bringing it to your notice.

(1) Read at the Annual Meeting of the Medico-Psychological Association of Great Britain and Ireland at York on July 22nd, 1919.—(2) *Brit. Med. Journ.*, June 14th, 1919.



*Notes on Two Cases of Epilepsy in Twins, with Photographs,*  
By R. M. TOLEDO, M.D., Resident Physician Government Lunatic  
Asylum, Malta.

SPECIAL features of interest in two cases of epilepsy in twin sisters under care in this asylum induced me to publish these short notes, although the cases do not exhibit anything particular from the clinical side.

Salvina O— (left photo) and Lorenza O— (right photo) were born eighteen years ago. Their father's grandmother and uncle both died in this asylum, the former from senile dementia, the latter from tumour of the brain. No history of alcohol or syphilis in the family.

Both Salvina and Lorenza had their first attacks when eight years old, within a few weeks of each other. The fits were never accompanied by mental disturbance, and the children could be safely kept at home till their first attack of delirium, which occurred about a year ago. They both attended school with very little success.

Salvina was admitted to this asylum on August 30th, 1918, in a very excited condition. She was completely disorientated, restless and exhibiting aggressiveness. The relatives reported that it was the first time that the girl could not be managed at home.

Lorenza followed her sister to the asylum after a couple of months with the same symptomatology, and, as in the case of Salvina, it was the first epileptic delirium exhibited by the patient. Both sisters had their first menses at the age of thirteen, and these ceased on the supervening of the delirium. The amenorrhœa still persists in both cases.

A point of interest is the fact that always, or nearly so, the appearance of the delirium in Salvina is followed by that of Lorenza, necessitating the warding of both sisters with the dangerous patients. The delirium is always of short duration, and marked more by restlessness than by aggressiveness.

Quite lately while Salvina was under a very severe attack of delirium Lorenza was in the infirmary in a regular status epilepticus from which she slowly recovered.

Both sisters are feeble-minded, and when free from delirium they are useful helpers in their ward. While Lorenza is always morose and gloomy, Salvina is cheerful, laughs, is coquettish in her manners, adorns herself with bright-coloured ribbons, and she is particularly fond of squeezing and kissing the assistant physician's hand on his rounds. This mood of hers helps us to distinguish at once Salvina from her sister, as their features and their figures are almost identical, save perhaps that Lorenza's nose is very slightly flatter than that of her sister. Both sisters weigh 8 st. and their height is 5 ft.



To illustrate paper by Dr. R. M. TOLEDO.

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### Occasional Notes.

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#### *The Late Dr. Charles Arthur Mercier.*

A fine personality and untiring intellect has gone to rest in the death of Dr. Charles Arthur Mercier, who was gathered in on September 2nd, 1919.

He occupied an unique position in medicine and philosophy. He had a mentality of absorbing interest, and one about which, no doubt, there will be many divers views, but all who knew him will agree that his demise has created a vacancy in the intellectual world which can never be filled. There can be no second Mercier, and his loss will be keenly felt in more directions than one.

He was well known to us on the Editorial Staff of this Journal, to which he contributed freely, and it is fitting that our pages should contain an authoritative memoir of him. Sir Bryan Donkin has kindly undertaken this for our next number.

We shall be glad also to publish any recollections of him which Dr. Mercier's many friends and acquaintances may think fit to send us.

In the meantime, we republish in "Notes and News" the *Times* summary of his life and works.

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### Part II.—Reviews.

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#### *Sixty-seventh Annual Report of the Inspectors of Lunatics (Ireland) for the year ending December 31st, 1917.*

The statistics of lunacy for the year 1917 show a very material diminution in the number of insane under care in Ireland. This is the third year in succession in which a reduction has been recorded, and not only this, but a progressively advancing reduction, the decreases for the three years 1915, 1916 and 1917 having been respectively 77, 337 and 874. Although caution in forming conclusions on merely statistical grounds has been frequently urged in these columns, it cannot be denied that the figures for the past several years have clearly shown, first, a tendency to fall, as indicated by a reduction in the rate of increase from what it was in previous years, and now for the past three years there has been an absolute and progressive decrease in numbers to the extent above stated, so that each successive year seems to bring us a more certain assurance that insanity in Ireland has passed its zenith and is on the downward grade. The proportion of insane under care per 100,000 of estimated population for the years 1915, 1916 and 1917 has been 579, 571 and 551 respectively—a reduction during the two years 1915–1917 of all but 5 *per cent.* The admissions have also fallen from 3,538 to 3,444 in 1917,—a drop of 94—the number



admitted into District Asylums having decreased by 133, while they increased by 39 in the case of Private Asylums. First admissions into District Asylums decreased by 143, while re-admissions increased by 10. The proportion of total admissions per 100,000 estimated population decreased from 75 to 72 and in the case of first admissions from 60 to 57. It is a matter for regret that tables which have hitherto appeared giving statistics for a series of years as regards admissions, discharges, and deaths are omitted from the Inspectors' report—let us hope only temporarily—and now that war conditions no longer exist that publication of these tables will be resumed in future reports.

The Inspectors attribute the reduction in the number of insane mainly to the unusually high death-rate—10·5 *per cent.* on the average number resident, as compared with 8·1 in 1916, which was also the rate for the whole quinquennium 1913–1917. This rise in the death-rate is regarded as due principally to two causes—(1) long-continued cold and inclement weather at the end of 1916 and during the spring of 1917, accompanied by an outbreak of influenza; and (2) the adverse effect of the war on food, chiefly bread, the unpalatability of which, combined with the total or partial deprivation at times of tea, sugar, milk, eggs, butter, etc., gave rise to digestive ailments, and thereby reduced the vitality of already enfeebled patients. These conclusions are based upon the opinions of the medical superintendents, and are, no doubt, true to some extent, but patients in Irish asylums suffered but little in comparison with those in the sister countries. The death-rate has been increasing in recent years, and it is probable that this is due in great measure to the fact that each year the proportion of patients who have reached the average duration of life is increasing—and will, no doubt, continue to increase—so that a higher death-rate is to be regarded not so much as a matter of surprise as a not unexpected contingency. The ratio of deaths from phthisis continues to decline, the proportion having fallen from a maximum (1895–1899) of 29·2 *per cent.* of the total mortality to 20·3, the ratio for 1917. The relative mortality from general paralysis has also fallen, its maximum having been 4·4 *per cent.* during the quinquennium 1910–1914, while it was only 2·7 in 1917. The ratio of deaths from epilepsy, on the other hand, appears to be on the increase. The average mortality due to this disease for twenty-five years ending 1914 was 4·8 *per cent.* of the total; in 1917 it was 6 *per cent.* As usual the death-rate in individual asylums shows great differences, ranging from a minimum of 6·1 in Ennis asylum to a maximum of 15·4 in Belfast. Only 156 *post-mortem* examinations were made—a fraction over 7 *per cent.* of the number of deaths.

The recovery-rate shows similar variations, the highest record being 56·3 in Clonmel and the lowest, 23·1, in Waterford. This is omitting Sligo, with respect to which we are convinced there must be some error in the figures, the percentage of recoveries on admissions being given (Table VI) as 6·4 and that of recoveries on daily average as 8·8—an obvious impossibility, as the former ratio should be from at least three to seven times as large as the latter. The general recovery-rate for all District Asylums was 37·7, or 4 *per cent.* lower than that of the previous quinquennium.

As to causation heredity was an element, either principal or accessory, in 16·87 of the admissions, and alcohol was a factor in 9·41 *per cent.*, but in only 6·38 *per cent.* was it a principal cause—a ratio which was well under the pre-war rate. The restrictions on the use of stimulants which were found necessary under war conditions seem undoubtedly to have had a beneficial effect as regards at least one of the results of over-indulgence. Mental stress operated as a cause in 20 *per cent.* of the admissions, which was somewhat over the proportion in the previous year. But in only 1·16 *per cent.* was the war assigned as a cause, and a principal cause in only 0·64 *per cent.*—an amount so small as to be practically negligible, although the ratio is somewhat higher than in either of the two preceding years, when it was 0·32 and 0·48 respectively. The number of soldiers and sailors admitted in whose cases the war was assigned as a factor in causation was 150, only 68 of whom had seen active service. So far, therefore, the war cannot be said to have had more than a very trifling effect in causing insanity, having regard to the comparatively few cases of military or naval men who were sent to asylums. But it must not be forgotten that mental cases occurring in members of both services were treated in other institutions, where probably most of them were of temporary duration and ultimately recovered. Of such cases we have no available statistics.

As regards expenditure, in the case of District Asylums this has increased considerably. The total cost was in round numbers £780,736, or well over three-quarters of a million. In 1900–1901 it was £460,282, or less than half a million, the actual increase during the intervening period having been 59 *per cent.*, while the increase in the daily average has been only 31 *per cent.* It is to be feared that this expenditure has by no means reached its limit, as during the last two years in practically every department of asylum service the cost of everything, and notably as regards the wages of attendants, has gone up by leaps and bounds, and there is, we fear, but little likelihood of any reduction in cost for some considerable time to come, if, indeed, it will ever come. The unrest which has been for a long time seething amongst the staffs of asylums, as in the case of other branches of labour, owing to dissatisfaction with the existing regulations in respect of wages and hours of work, has during the past year culminated in general strikes in not a few of these institutions, and committees have had to make liberal concessions in both directions. It was quite right that the pay of attendants should be largely increased under present conditions, but, as a matter of fact, even in pre-war times adequate remuneration was never given to asylum attendants, having regard to their important and responsible duties. But there is nothing to justify their making exorbitant demands such as have been made at the instigation of outside “organisers,” and which there is good reason to believe have not received the approval of a large number of the more moderate and sober-minded members of the staffs, who realise that they occupy a position wholly different from, and superior to, that of the ordinary trade-union factory hand, and feel that extreme measures, while possibly securing to them advantages at the expense of a long-suffering public, are lowering to their self-respect and the dignity of their calling, and by simply appealing to purely selfish instincts can

only have a deteriorating effect on their character. It is to be hoped that with time saner counsels will prevail, and that a mutual feeling of conciliation, leavened with an unselfish desire to give of their best for the good of the community and the welfare of their patients, will be the animating principle of their lives and work.

The Inspectors report favourably on the condition of private asylums generally. That of patients in workhouses does not seem to be altogether satisfactory, especially as regards facilities for bathing and sanitary accommodation, which in many instances are far below the standard which we have reason to expect in these enlightened days. The query suggests itself: Is there proper and adequate supervision in these institutions by the management, both lay and medical? And if not, why not?

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*Mental Diseases.* By R. H. COLE, M.D., F.R.C.P. Second edition. London: University of London Press, Ltd.

The publication of the second edition of *A Text-book of Psychiatry for Medical Students and Practitioners* is an indication of the deserved popularity of this work. This edition, which is well illustrated, has been carefully revised and brought thoroughly up-to-date.

Four chapters are devoted to psychology and neurology, a knowledge of which, as the author contends, is essential to the understanding and treatment of psychiatry. These subjects are dealt with in such a manner that the student should have little difficulty in understanding them.

Dr. Cole's classification of mental diseases is a useful one, and is to be commended.

Special reference is made to the psychoneuroses arising from the war, to treatment by psycho-analysis and other methods, and to the necessity for amendment of the existing legislation to meet the present defects.

This book, in short, will be found most useful to those for whom it is intended.

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*Studies in Forensic Psychiatry.* By BERNARD GLUECK, M.D. London: William Heinemann, fol. 266.

This volume is one of a series of monograph supplements to the *Journal of Criminal Law and Criminology*. It is of interest to the lawyer as well as to the psychiatrist, and it should do much to make clear to the layman the modern view-point of the psycho-pathologist in regard to one aspect of criminology. The whole subject of crime and punishment is extremely complex and difficult, but the sentence which the author quotes from Franz Joseph Gall as long ago as 1810 aptly sums up the attitude of the criminologist of to-day: "The measure of culpability and the measure of punishment cannot be determined by a study of the illegal act, but only by a study of the individual committing it." Perhaps the truth of this is only now beginning to be realised, and, as Dr. Glueck says, "The suppression of crime is not primarily a legal question, but is rather a problem for the physician, sociologist, and economist. . . . The slogan of the modern criminologist is "intensive

study of the individual delinquent from all angles and points of view " rather than mere insistence upon the precise application of a definite kind of punishment to a definite crime as outlined by statute. Indeed the whole idea of punishment is giving way to the idea of correction and reformation. . . . For criminology is an integral part of psychopathology, crime is a type of abnormal conduct which expresses a failure of proper adjustment at the psychological level."

The first chapters are devoted to the consideration of what are commonly known as the "prison psychoses." These cases belong, of course, to the wider group of what are known as the "psychogenetic" or "situation psychoses," so-called since they are immediately caused by a painful situation in the environment. The study of these cases has been curiously neglected in this country, though much attention has been given to them in Germany, and in America the name of Dr. Glueck is especially associated with careful studies of cases belonging to this category. Perhaps if it had been more generally recognised that many cases presenting a dementia præcox-like clinical picture are liable to occur with severe environmental stress, and to rapidly clear up when the stress is removed, less mistakes in diagnosis would have been made in connection with the war psychoses. Many civil psychoses, which clear up rapidly when removed from their usual environment to a mental hospital, probably belong to the group of the psychogenetic psychoses, and the interest of the subject is by no means limited to those cases which occur in prisoners awaiting trial or undergoing punishment. The discussion of this subject in this volume, together with an excellent description of a number of cases, will be found well worth the attention of all those interested in the study of mental disorder, both from the purely clinical standpoint as well as that of criminology.

A chapter is devoted to the study of "litigious paranoia," and a full and complete consideration is given to the question of the malingerer, both these subjects being illustrated by descriptions of concrete cases. These subjects contain material of much interest to the psychiatrist, and the psychological problems which they involve are discussed from a modern view-point which will be found helpful and illuminating. The last chapter contains a psycho-analytic study of a case of kleptomania which serves to suggest the value of an intensive individual approach in attempting to understand morbid mental phenomena.

This book may be thoroughly recommended and will well repay careful study, not only from the point of view of criminology, but from its wider implications. It serves to illustrate that insanity is not only a matter of classification, but it is a type of abnormal reaction to life, the significance of which can only be understood by a study of the psychogenetic factors which play a part in its production. H. DEVINE.

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*Rational Sex Ethics.* By W. F. ROBIE, M.D. Boston: Badger. London: Stanley Phillips, 45, Brondesbury Road. Pp. 356. Price 15s.  
*Sane Sex Life and Sane Sex Living.* By H. W. LONG, M.D. Same publishers. Pp. 157. Price 25s.

These two volumes are examples—more favourable examples, it may be added, than might easily be chosen—of the most modern  
LXV.



medical attitude in America towards those sex problems which now seem to be attracting so much attention, medical and lay. They are written from a fairly concordant standpoint, and the author of the first has furnished an introduction for the second volume, but the scope of the two works is entirely different, although both are sold only to professional readers.

Dr. Robie, who is superintendent of a sanatorium for functional nervous disorders, begins with a little autobiography, not, as he remarks, for "the purpose of emphasising my own modest ego," but in order that the reader may be enabled to appreciate that bias and "personal equation" which, in approaching questions of sex, must always be important. The practice, though unusual, seems commendable, and in any case it is characteristic of the author's American directness and simplicity. The book is not a systematic treatise of sexual morality. It is much better described in the sub-title as "A physiological and psychological study of the sex-lives of normal men and women, with suggestions for a rational sex hygiene with reference to actual case-histories." The chief value of the book lies in these histories—many of them quoted or reproduced—of 95 more or less normal persons (61 men and 34 women), while the author also possesses the sexual histories of some 150 additional persons, the majority females. Special attention seems to have been given to masturbation. All but a very small percentage admitted practising or having practised masturbation, or some form of conscious auto-erotism, the women nearly as often as the men, although they indulged in it much less frequently—usually from two to five times a month, about the period of menstruation. This was regarded by many of the women as perfectly normal; they usually abandoned the practice at marriage but seldom before. In accordance with the results found by other recent investigators, Robie finds also that of 500 young people known to him to have masturbated for longer or shorter periods (and many excessively), "none were ever known to have suffered in any way from the results of this habit." To this question the author refers again and again throughout the book. He does not, he tells us, advocate masturbation, and he is aware of its harmfulness in morbidly predisposed subjects, but "I am prepared," he tells us, "to maintain that while, act for act, auto-erotism is as harmless as ordinary promiscuous intercourse—more harmless if account is taken of the venereal danger—there is far greater relief of sexual tension, a more complete orgasm, and infinitely less shame, disgust, and self-condemnation in this practice, provided one knows the actual facts about it."

Taken altogether, however, the author's ethical attitude is unquestionably orthodox and conventional. He has much sensible advice to give on the hygiene of marriage; he rightly insists, as it is now becoming usual to do, on the importance of a knowledge of the art of love to ensure conjugal felicity. He discusses intercourse during pregnancy and approves of it. Although he regards the exercise of birth control as necessary at some time or other for all, he approves of every healthy married couple having from two to twelve children.

While the book is helpfully instructive and written in an engagingly ingenuous manner, its method is not altogether scientifically satisfactory.

The style is careless; the names, even of well-known fellow-countrymen of the author himself, are frequently misspelt; the arrangement of chapters is unsystematic and casual. A considerable amount of space is occupied in summarising the opinions of other authors whose books are fairly well known and accessible. Freud is in this way responsible for a considerable amount of space, but the author shows his usual moderation and practical common-sense in his judgments of psycho-analytic doctrines. He himself has adopted something of the methods of mental analysis, but he is convinced, from his own extensive observations, that while there is much more sexuality in the child than the older writers admitted, the early years of life are not so universally sexual as Freud believes, and thumb-sucking or similar manifestations, while almost general, cannot be regarded as always a sexual manifestation. Nor, though the love of the child for the parent has at times an undoubtedly sexual character, can the "Œdipus-complex" be regarded as universal, for he has witnessed the recovery of neurotics in whom it was never revealed, and on Freudian principles such recovery would be impossible. He also disagrees absolutely with Freud that the fruitful investigation of sex matters in women by ordinary methods is impossible on account of their reticence and dishonesty, and finds on the contrary that when a woman is convinced of its desirability it proves more fruitful than in men. The author's temperate conclusions on these points will be approved by all but the more extreme of Freud's disciples.

Dr. Long's book is misleadingly described by the publisher on the wrapper as "a thoroughly scientific treatment of a subject which has heretofore been treated in a merely empirical manner." The author himself in his first paragraph more truly describes it as "more a heart-to-heart talk between those who have mutual confidences in each other than a technical or strictly scientific treatise." Although only sold to the professional reader it is for the lay reader that it is intended, and it is written throughout in simple language. Like many other doctors nowadays, Dr. Long is frequently consulted by young husbands or wives who are suffering from ignorance or misapprehension concerning the conjugal relation, their difficulties often being complicated and obscured by reticence and timidity. As he was unable to find any manual which dealt simply, and in all the detail necessary for those who are ignorant, with the necessary facts of the art of love and the science of procreation, he wrote a manuscript covering the chief ground, and has been in the habit of handing it over in these cases to be read privately. Being impressed by the advantage of this method for the patient, as well as the saving of time for the physician, he has re-written and enlarged this manuscript. The result is the present volume, "prepared for the sole and express purpose of helping husbands and wives to live sane and wholesome sex-lives—to give them the requisite knowledge for so doing; knowledge of themselves and of each other as sexual beings; the correct ideas regarding such manner of living; to disabuse their minds of wrong sex-teaching, or no teaching at all, of ignorance, or prudery, or carelessness, or lust." Nothing is said of perversions or anomalies, or even of venereal disease, but everything bearing on the ordinary love-life in marriage is clearly set forth and

fully discussed. The advice given is not at every point in accordance with traditional maxims, but it is in accordance with modern scientific knowledge, and usually shows practical sagacity as well. Dr. Long is to be commended for the courage, skill, and sympathy which he has shown in writing a book, almost unique in character, which will certainly prove of immense help to many readers.

HAVELOCK ELLIS.

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*Experiments in Psychical Research.* By JOHN EDGAR COOVER, Assistant Professor of Psychology, Leland Stanford Junior University. Stanford University California, 1917. Pp. 641. Price 4 dollars.

This substantial and important series of studies requires some time to master—all the more since it is furnished with no summary of conclusions—and review notice has thus been unduly delayed. It is supplied with a foreword by Chancellor David Starr Jordan, an introduction by Prof. Frank Angell, and the author is a highly trained and experienced psychologist of judicial temperament. So impressive a piece of work, proceeding from the "Division of Psychical Research" of a noted University, deserves serious consideration. Respectability, though by no means universal belief, has been conferred upon the conclusions put forward by the Society for Psychical Research by the distinguished reputations of some of those who have endorsed those conclusions. But, as Prof. Angell here remarks, "it must be said with the utmost frankness that the mantle of Sir Oliver Lodge's great reputation as a physicist cannot be stretched to cover his work in psychical research, and it is doubtful if Sir William Crooke's authority as a chemist has perceptibly swayed the minds of his colleagues in chemistry towards spiritualistic belief." It is special training in psychology which is necessary for such investigations, a wide acquaintance with motor automatisms and subliminal impressions, a training in the ideational and affective processes underlying belief and conviction, in illusions of perception, and in the value of evidence. The value of the present series of investigations lies largely in the fact that it has been conducted by trained psychologists.

The work falls into five parts (amply illustrated by diagrams, charts, and plates), dealing successively with thought-transference, subliminal impression, mental habit and inductive probability, sound-assimilation, and miscellaneous contributions (pseudo-prophecy, local ghosts, automatic writing, etc.) by Prof. Lillian Martin. There are numerous appendices, and a list of books dealing with the subject in the University library which constitutes a formidable bibliography of over sixty pages.

The problem of thought transference, a mental power by many regarded as proved, is approached by a variety of methods. There is, for instance, the guessing of lotto-block numbers, which in the experiments conducted by Mrs. Henry Sidgwick furnished support for thought-transference. The conditions of the experimentation at Stanford University and the attitude and training of the reagent seemed to promise a like favourable result, but this result was far from ensuing: a thousand experiments indicated that the number of successful guesses

is not beyond either experimental or theoretical probability. The investigators agree with Prof. James that Richet's belief that thought-transference is a common capacity to be found in any long series of guesses "is probably wrong." It was incidentally established that normal persons refer subjective experiences with a varying degree of certainty to an objective source. This tendency, as is here pointed out, indicates that the psychical processes of illusion and hallucination are, in an incipient form, both common and normal. Investigations with playing cards, carried out with both normal and "sensitive" reagents, and elaborately described in nearly one hundred pages, led to similar conclusions; although some of the deviations, by consistency and size, seemed to be beyond chance, they were yet matched by chance deviations, and the psychics showed no advantage over normal reagents. The "feeling of being stared at" was also investigated. It involves a telepathic process—that is, the becoming aware in a super-normal way of a specific voluntary action of another person. It is widely accepted; at Stanford University 77 *per cent.* among nearly 1,300 young men and women from all corners of the earth affirmed that they had experienced it. Experiment showed, however, no results that could not be perfectly well explained by chance; an objective validity is attributed to subjective impressions in the form of imagery, sensations, and impulses. This seems a common trait in normal adults, but in its final manifestations it becomes hallucinations and motor automatisms.

The most frequent explanation brought forward of the alleged phenomena of thought-transference is that of subliminal perception of signs and signals involuntarily given. It is supposed that the reagent unconsciously receives impressions of the signs involuntarily given by the agent. This explanation is, for instance, invoked to explain the marvellous accomplishments of the horse "Clever Hans," though, it must be remarked, it can only explain correct answers that are known to the agent, and the Mannheim dog, for example, could, it was alleged, give correct answers (as of the number of violets in a bunch) that the agent was unable to count.

Part II, which deals with investigations into this "subliminal impression"—by means of the tachistoscope and other methods—is too varied and elaborate to be summarised, but the general conclusion may be stated: there is some experimental evidence of the existence of that "fringe of perceptions, most often unconscious, but all ready to enter into consciousness, and in fact entering in certain exceptional cases or certain predisposed subjects" with which Bergson has insisted that "psychical research" should concern itself; it is, moreover, more than probable that this sort of perception has played a part in the evidence for telepathy gained from experiments and the *séance*-room, and further investigation may determine the extent of the influence of subliminal impression upon judgment in (a) normal subjects when the stimuli are not removed so far from the lines of normal perception, and when the stimuli are varied over the sense modes, and (b) in "sensitive" or "psychic" subjects.

In Part III inductive probability and the influence of mental habit upon judgment are most instructively studied by statistical methods. The influence of mental peculiarities in the general population is shown



by the age-returns in the census, in the terms of criminal sentences imposed by judges, in the registration of temperature, rainfall, star-transits, and in various other ways, and the bearing of these inquiries on the attempts to prove thought-transference is duly set forth. The infinitesimal probability is also set forth, the fallibility of human testimony and the operation of normal extra-chance causes.

In Part IV it is shown that sound-assimilation is very potently influenced by suggestion. The perception of a word is not, as is commonly supposed, a purely auditory affair. The auditory impression may be slight and inadequate, but become assimilated by more powerful psychic factors (images, motor dispositions, etc.), which assume primary responsibility for the cognition of the word. This assimilating process leads to illusions. All the other senses are similarly capable of reporting facts that are not there.

There is to-day a wide-spread revival of interest in phenomena of the supra-normal (as we have usually understood "normal") order. Hence the value of a series of studies so expert, so many-sided, and so impartial as we find in this volume. It furnishes a valuable armoury for those who have committed themselves in opposition to such tendencies, and it demands the most strenuous attention of those who accept them.

HAVELOCK ELLIS.

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*Spirit Experiences.* By CHARLES A. MERCIER, M.D. London: Watts & Co.

"A little nonsense now and then  
Is relished by the wisest men."

This booklet has been sent to us for review. To review it seriously would be difficult, if not impossible. Professedly, if we may judge by the rather sensational amplification of the title as "The Conversion of a Sceptic! Startling and Astonishing Experiences of a Seeker after Truth—Unprecedented Marvels—Telepathy—Levitation—Communications with the Dead—Telergy—A Completely Novel Experience—Substitution," the writer offers it to the public as a sort of recantation of his published views on the subject of spiritualism. Whether it is, or is not, must be left to the individual reader to decide for himself. In reality it is a humorous skit on spiritualistic phenomena, its style and *motif* akin to that of a previous paper on "Dreams," which was read by Dr. Mercier at a meeting of the Association some years ago. The astounding occurrences which have made a convert of Dr. Mercier—and from what we know of that eminent psychologist, it is safe to assert that any agency capable of converting him from any view he may have adopted regarding any question whatever must be nothing less than astounding—are detailed in a manner, if droll, at any rate circumstantial, and can hardly fail to convince even the most hardened and uncompromising opponent of spiritualism of the error of his ways, and bring about his "conversion" to the true faith. The interviews with Hodgkins, who when in the flesh had been "a bit of a rip," and who spoke from a region where asbestos clothes were worn—"nothing else would stand the heat"—and where the daily fare was "roast

salamander, always cooked to death," and with Mrs. Shegessdit—a name full of significance—are diverting reading. And the real meaning of such performances as the three-card trick (no longer a mere "trick") and thimble-rigging (nothing to do with sleight-of hand), as explained on occult and spiritualistic principles, form a suitable climax in this amusing—and amazing—brochure.

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### Part III.—Epitome of Current Literature.

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*War Neuroses and Military Training.* (*Mental Hygiene*, October, 1918). Rivers, W. H. R.

In this report to the Medical Research Committee Dr. Rivers concisely sets forth some of the results of his experience. War neuroses, he finds, fall into three main groups: (1) Hysteria, though the term is admitted to be unsatisfactory; there is some definite physical symptom (paralysis, deafness, mutism, etc.), such as can be readily produced by suggestion in hypnosis. (2) Anxiety neurosis, but usually termed neurasthenia; there is physical fatigue and organic slackness with, on the mental side, irritability or depression. (3) Definite psychic manifestations; there are many varieties—including a manic-depressive tendency, morbid impulses such as to murder or suicide, obsessions, phobias—but the special feature is always a resemblance to the definite psychoses, but yet without the severity or fixity which renders any legal restriction on the patient necessary.

There seems nothing specially original in the grouping. Dr. Rivers proceeds, however, to bring forward some interesting considerations with regard to the varying incidence of these groups of disorders respectively on officers and on men. There is no reason to suppose that the third group are specially liable to affect either officers or men. But of the other two groups hysteria is almost exclusively confined to the men, while anxiety neurosis, though not similarly limited to officers, affects them much more frequently and much more profoundly. This difference, Dr. Rivers seeks to show, is largely explainable by the varying conditions of training and duties in the two classes. "The neuroses of war depend upon a conflict between the instinct of self preservation and certain social standards of thought and conduct, according to which fear and its expression are regarded as reprehensible." In cases of the first group the conflict is solved by some disability which incapacitates the patient from further participation in warfare. In the second group the conflict is not solved, but rendered more acute by weakening of the social factor through strain, etc. One cause of the difference is the superior education of the officers, which renders them subconsciously dissatisfied with the easy hysterical solution of the conflict. Another possible cause is the greater repression of fear in the officers' early education. The first aim of military training is to enable the soldier to act in harmony with the aggregate, and the agencies are habituation and suggestion. The next great aim is to enable him to withstand the strain of warfare, and the

chief agencies are repression and sublimation (of which *esprit de corps* is an important development), together with side-tracking (of which swearing, conviviality, and athletics are all manifestations). Of these main agencies upon which the success of military training depends, suggestion acts most potently on the private, sublimation and repression on the officer. It is thus that military training tends to determine the character of the neurosis from which each will suffer.

The present unsatisfactory character of the nomenclature is dealt with. For "hysteria" Dr. Rivers rejects Babinski's proposed term "pithiatism," as well as Freud's "conversion neurosis," and considers that "suggestion neurosis" would be the appropriate term. He defends the use of Freud's term "anxiety neurosis" for the "neurasthenia" group, but uses it in a wider sense than Freud. The appropriate treatment is to lessen suggestibility by re-education, and in regard to anxiety neurosis to concentrate on prevention. Most success, as Dr. Rivers has elsewhere stated, has been attained by a mental analysis resembling Freud's psycho-analysis, but not attempting to go deeply into the unconscious.

HAVELOCK ELLIS.

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*The Rôle of Focal Infections in the Psychoses. (The Journal of Nervous and Mental Diseases, March, 1919.) Cotton, H. A.*

In this paper the writer urges the important part played by chronic, masked, or focal infections in the production of the psychoses. His cases are submitted to a most thorough bacteriological examination on modern lines, and special attention is paid to the teeth, which are examined by the dentist and if necessary radiographed. Most of the focal infections due to streptococci have their origin in the teeth, and in the course of time these organisms reach remote organs and other structures. In support of his views case histories are given and included under three headings: (1) Severe cases of mania all of whom died, and the autopsy revealed the cause of death as bacterial infection. (2) Hypomanic cases, which cleared up rapidly under treatment. (3) Profound depressions, clearing up when the infection was recognised and treated.

As a result of these researches the following points are emphasised:

That the organisms concerned in focal infections in these cases belong to the slow-growing, non-pus-producing type which are extremely toxic, their origin is usually the teeth, and they may so spread as to persist after the teeth are extracted.

That a thorough search for chronic infection is imperative, and that bacteriological examination should be an essential part of the work in every hospital for the insane.

That prophylaxis in mental disease should include the education of physicians and the public in regard to the fact of dental infections, and dentists should realise the damage resulting from faulty dental work.

That many psychoses could be prevented, and chronic psychoses cured, if these principles were followed in treatment.

H. DEVINE.

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## Part IV.—Notes and News.

### THE MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

THE SEVENTY-EIGHTH ANNUAL MEETING was held at York on Tuesday and Wednesday, July 22nd and 23rd, under the presidency, in the early part of the proceedings, of Lieut.-Col. Keay, and later that of Dr. Bedford Pierce.

*There were present:* Drs. T. Stewart Adair, Dora E. Allmann, David Blair J. Shaw Bolton, C. Hubert Bond, David Bower, Geo. L. Brunton, Wm. M. Buchanan, Robert B. Campbell, James Chambers, W. R. Dawson, Thos. Drapes, C. C. Easterbrook, S. Edgerley, Francis H. Edwards, Henry M. Eustace, J. Tylor Fox, Claud F. Fothergill, J. W. Geddes, J. R. Gilmour, Percy T. Hughes, P. Rutherford Jeffrey, John Keay, Walter S. Kay, R. Macd. Ladell, S. Langton, Oliver Latham, H. J. Mackenzie, W. F. Menzies, J. E. Middlemiss, George E. Miles, Alfred Miller, Gilbert E. Mould, Alex. W. Neill, Wm. F. Nelis, Norman Oliver, L. R. Oswald, B. Pierce, Daniel F. Rambaut, George M. Robertson, D. Maxwell Ross, E. S. Simpson, R. Percy Smith, J. G. Soutar, Charles T. Street, R. C. Stewart, W. G. Thomson, A. H. Trevor, Marguerite Wilson, J. C. Wootton, and R. Worth (General Secretary). Visitors: Dr. H. Colin, Marjorie Pierce.

#### MORNING SESSION.—TUESDAY, JULY 22ND.

Held at the Retreat, Lieut.-Col. Keay in the chair.

#### MINUTES.

The minutes of the last Annual Meeting, having appeared in the Journal, were taken as read and approved.

The PRESIDENT put from the chair the following series of resolutions, all of which were approved:

(a) That the officers of the Association for the year 1919-20 be:

*President.*—Dr. Bedford Pierce.

*President-elect.*—Dr. W. F. Menzies.

*Ex-President.*—Lieut.-Col. John Keay.

*Treasurer.*—Dr. James Chambers.

*Editors of Journal.*—Lieut.-Col. J. R. Lord and Dr. Thomas Drapes.

*General Secretary.*—Major R. Worth.

*Registrar.*—Dr. A. A. Miller.

(b) That the nominated Members of Council be:

A. Helen Boyle, G. E. Shuttleworth, David Orr, Lieut.-Col. D. G. Thomson, R. D. Hotchkis, J. G. Smith.

(c) That F. H. Edwards and G. F. Barham be appointed Auditors.

(d) That the Parliamentary Committee be re-appointed and that Nathan Raw, M.P., J. Shaw Bolton, A. A. Miller, J. N. Sergeant be added thereto.

(e) That the Educational Committee be re-appointed, and that T. P. Cowen be added thereto.

(f) That the Library Committee be re-appointed.

(g) That the Research Committee be re-appointed.

#### THE REPORT OF THE COUNCIL.

The SECRETARY read the report of the Council.

The number of members—ordinary, honorary, and corresponding—as shown in the list of names published in the *Journal of Mental Science* for January, 1919, was 626, as compared with 627 in 1918.

Number of new members elected in 1918 . . . . .	16
Number of members restored in 1918 . . . . .	1
Removed according to Bye-law 17 . . . . .	0
Number of members resigned in 1918 . . . . .	5
Number of deaths in 1918 . . . . .	11
Transferred to Hon. Members . . . . .	2



Endeavours have been made to revise the list of Honorary and Corresponding Members. So far we have only been able to ascertain that Dr. H. Schule died in December, 1916.

The following table shows the membership for the past decade: 626 + 32 + 18. Total, 676.

Members.	1909.	1910.	1911.	1912.	1913.	1914.	1915.	1916.	1917.	1918.
Ordinary . .	673	680	690	696	695	679	644	632	627	626
Honorary . .	32	33	34	35	34	34	34	32	33	32
Corresponding .	17	17	19	19	18	18	18	18	18	18
Total . .	722	730	743	750	747	731	696	682	678	676

We have to record the retirement of Dr. R. H. Steen from the post of General Secretary of the Association. Dr. Steen's work as Secretary during the trying years of the war was invaluable, and the very able manner in which he carried out his duties is beyond praise.

Major R. Worth, Superintendent of the Springfield Mental Hospital, has been appointed in his place.

The Special Committee appointed to draw up the English Legislation Report, after a great deal of time and thought, placed their recommendation before the General Meeting held in November, 1918. The report was unanimously approved and adopted, and 1,500 copies circulated. Special Committees have been appointed to deal with the following matters:

The Formation of Divisions Overseas.

The College of Nursing and Nurses' Registration Bill.

The Ministry of Health.

The recommendation of the Special Committee appointed to draw up a report on the Maudsley Bequest was approved and suggestions carried as to how and where lectures were to be given.

Dr. Soutar was appointed to represent the Association on the recently constituted Parliamentary Medical Committee.

It was decided that standing sub-committees should be limited in size.

Special meetings of the Association were held in March to go into the question of Asylum Administration.

A new bye-law affecting the seal of the Association was passed at the May meeting.

Sub-committees were formed to attend Guildhall Conference of Visiting Committees to assist them in their deliberations.

We have to record with the deepest regret the death of Dr. Wigglesworth, President of the Association in 1902.

The PRESIDENT announced that in connection with the Maudsley Lectureship the Council had proposed to invite Sir James Crichton Browne to deliver this lecture at the quarterly meeting to be held in London in May.

This was agreed to.

#### TREASURER'S REPORT.

The TREASURER submitted the Revenue Account and Balance-sheet for the year 1918.

He stated that in accordance with the instructions given by the Council the Maudsley Bequest had been invested in 5 *per cent.* War Loan, and acting on the advice of the Association's solicitor the Council had decided to make the investment in the name of the Medico-Psychological Association. Similarly, instead of appointing new trustees for the other funds of the Association, it had been decided to make future investments in the name of the Association, and to have existing investments transferred from the surviving trustee to the Association.

# THE MEDICO-PSYCHOLOGICAL ASSOCIATION.—For the Year 1918.

## REVENUE ACCOUNT—January 1st to December 31st, 1918.

1917. £ s. d.	Dr.	Expenditure.	£ s. d.	£ s. d.	Income.	£ s. d.	Cr.	1917. £ s. d.
518 8 11	To	Journal—Printing, Publishing, Engraving, Advertising, and Postage	...	652 15 5	By Dividends—General Library	...	105 18 8	127 14 6
312 17 11	"	Examinations, Association Prizes, and Clerical Assistance to Registrar	...	300 3 6	" Sale of Journal	...	160 0 0	...
19 3 6	"	Petty Disbursements, Stationery, Postages, etc.	...	20 1 8	" " (Waste)	...	5 12 0	...
73 13 0	"	Annual, General, and Divisional Meetings	...	81 17 9	" " Handbook	...	18 1 6	...
103 12 0	"	Rent of Premises at 11, Chandos Street, care of Office, etc.	...	103 12 0	" " Statistical Forms, etc.	...	3 3 7	...
8 8 0	"	Audit and Clerical Assistance	...	8 8 0	" Advertisements, etc.	...	9 12 0	...
22 12 8	"	Miscellaneous Account	...	46 16 5	" Fees, Certificates of Psychological Medicine	...	196 9 1	183 7 2
1058 16 0		Balance	...	1213 14 9	" Certificates of Proficiency in Nursing	...	411 12 3	468 0 0
387 11 7			...	155 9 2	" Subscriptions	...	655 4 0	658 17 6
1446 7 7			...	£1369 3 11			£1369 3 11	£1446 7 7

## BALANCE-SHEET—31st December, 1918.

1917. £ s. d.	Liabilities.	£ s. d.	Assets.	£ s. d.	1917. £ s. d.
168 14 11	To Journal Account, balance of	140 10 2	By Lloyd's Bank—Bankers	...	142 4 5
35 17 6	" Examinations Account, balance of	83 8 0	" Sales Account, balance of	...	17 9 1
6 13 4	" Petty Disbursements Account, balance of	14 0 6	" Fees Account, balance of	...	148 7 3
14 16 9	" Meetings Account, balance of	25 18 0	" Subscriptions Account, balance of	...	593 19 4
25 18 0	" Rent Account	25 18 0	" Maudsley Bequest, balance of	...	24 5 6
5 5 0	" Audit and Clerical Assistance, balance of	...	" Stocks, value at this date:	...	...
2 4 9	" Miscellaneous, balance of	...	" New Zealand, 3½ per cent., 1940	...	488 9 7
114 16 1	" Library Account, Dividends	16 11 4	Do.	...	...
—	" Gaskell	166 7 8	Victoria, 3½ per cent., 1923	...	246 19 3
—	" Maudsley	24 5 6	Do.	...	175 15 0
374 9 4	Balance at 1st January	...	Manchester Corporation, 3 per cent.	...	57 17 6
	Add: Balance of Revenue Account	3559 5 6	New South Wales, 3½ per cent., 1930-50	...	139 0 9
	" Investments, appreciation of	155 9 2	Midland Railway Preference, 2½ per cent.	...	292 5 0
		97 13 10	War Loan, 5 per cent., 1929-47	...	309 10 4
		3812 8 6		...	1761 10 8
	Deduct:			...	3471 8 1
	Subscriptions written off	12 12 0		...	3123 14 3
	Library Dividend, 1917, transferred	8 8 6		...	...
		21 0 6		...	...
3559 5 6		3791 8 0		...	...
£3933 14 10		£4307 13 7		...	...

(Signed) JAMES CHAMBERS, TREASURER.  
(Signed) BOLT, GOODFELLOW & Co., F.S.A.A.

FRANCIS H. EDWARDS } AUDITORS.  
G. F. BARHAM }

£4307 13 7 £3933 14 10

This had necessitated the passing of a new bye-law with reference to the use of the seal of the Association, which was done at the General Meeting in May last.

At the present rate of income-tax the net yearly revenue from the Maudsley Bequest is £73 18s. By adding to this the interest which accrued from placing the bequest on deposit prior to its investment there will be a sum of £90 to the credit of this account at the end of the present year. Of the general funds of the Association a further sum of £250 was invested in 5 *per cent.* War Loan. Including the Gaskell and Maudsley Funds the amount invested in 5 *per cent.* War Loan is over £4,000.

The Revenue Account showed a serious increase in expenditure, due mainly to the increased cost of the work done by the printers. There is at the same time a large amount of unpaid subscriptions, with the result that the excess of income over expenditure is a narrow one. This state of matters has been considered by the Council, and a special Committee has been appointed to make a report on the financial position of the Association.

The TREASURER proposed the adoption of this report. Agreed.

#### THE EDITORS' REPORT.

Dr. T. DRAPES presented the report of the Editors:

Editors' reports during recent years have been mostly of an apologetic character. The world-wide convulsion, which has by no means completely subsided, has adversely affected certain kinds of journalistic literature, notably the scientific class. The same disabilities which were alluded to in last year's report continue still. Research work in these countries is at a minimum, although a few of our members have found it possible to make valuable contributions in this department of medical science to the Journal from time to time, amongst whom Dr. Orr and Lieut.-Col. Rows, in the sphere of purely experimental investigations, and Dr. Ford Robertson, in clinical and pathological observations leading to the adoption of effective therapeutic measures, are deserving of special mention, and merit our warm acknowledgments. But there has been a paucity of material generally which under normal conditions would have been disastrous to the Journal, although not so under existing circumstances, owing to which its size has had to be largely reduced, recent numbers, in fact, containing only about one-third the normal number of pages which they did in pre-war times. Of these circumstances two are outstanding as necessitating this great curtailment of size—the enormously increased cost of publication and, as the Treasurer has informed us, a material falling off in the funds at his disposal. In this respect we are, of course, not alone, as other medical journals have had to largely reduce their dimensions owing to similar conditions.

The Journal expenses for the year 1918 totalled £652. This is over £100 above the cost before the war. And as the dimensions of the Journal are only about one-third of what they were in the former period, it follows that the cost of production is over three times as much as it normally ought to be. However, necessity knows no law, and over this condition of things the Editors have absolutely no control. It is possible that a larger supply of paper may be now or may shortly be available, and, we must only hope, at a diminished cost. The item of labour expense is, we fear, not likely to get less, if it does not go on increasing. Whether it may be necessary or politic to raise the subscription to the Association is, of course, a question which must be decided by the members themselves.

We wish to renew our acknowledgments to the Assistant Editors for their valuable help, to Dr. McRae in particular for his very accurate and painstaking correction of proofs, and to Dr. Devine for his many interesting contributions to the Epitome section of the Journal—an important part of its content, and one which has suffered most from our restricted limits of space. And we are also grateful to those writers who have favoured us with contributions at a time when most members of our specialty were working at high pressure, and could command but little leisure from practical duties of management and the discharge of administrative responsibilities.

JOHN R. LORD.

THOMAS DRAPES.

The PRESIDENT said they sympathised with the Editors of the Journal in the period of difficulty through which they had been passing, and the Association should congratulate itself that it had men as Editors who had the pluck to carry on as they had done.

## THE AUDITORS' REPORT.

We beg to report that we have examined the Treasurer's accounts and checked the vouchers and receipts, and that the Balance-sheet represents a true and accurate statement of the financial position of the Medico-Psychological Association.

FRANCIS H. EDWARDS.

C. F. BARHAM.

Dr. EDWARDS, in presenting the report, said it was obvious to them as Auditors, in going through the accounts, that the difference between income and expenditure had reached a serious stage, coming down to practically a few pounds. Although the financial position of the Association was a strong one, they must recognise they had been working with a Journal much reduced in size. It was obvious there could not be any very material reduction in the cost of printing or paper, and it was therefore necessary to draw very forcible attention to this state of affairs. They had heard that a Committee was about to be appointed to consider the whole financial situation, and he need not therefore comment further on it.

The report was agreed to.

## REPORT OF THE EDUCATIONAL COMMITTEE.

The SECRETARY read the report of the Educational Committee.

The following is a brief account of the work which has been carried out by this Committee:

As in former years four meetings have been held, and the attendances, considering the abnormal conditions, have been quite up to the average of recent years.

The Registrar reported that at the November and May Examinations 674 candidates presented themselves for the Preliminary Examination and 537 for the Final, the total being 1211. On comparing the total entries for the Nursing Certificate Examination, 1918-1919, a still further decrease is shown, those for 1917-1918 being 1,382.

At the November examination 105 candidates passed the Preliminary and 89 the Final. The results of the May examination are not yet to hand.

Up to the present one candidate has entered for the Preliminary Examination and the Mental Deficiency Nursing Certificate.

The professional Certificate and the Gaskell Prize Examinations were not held in 1918. A divisional Prize of ten guineas has been awarded to Dr. Hubert J. Norman for his paper entitled, "A Plea for Optimism in Psychiatry."

Owing to the ravages of influenza in the majority of institutions it was found necessary to postpone the Nursing Examination from November to December.

The Special Committee dealing with the question of the Nurses' Registration Bill have watched the interests of the Association.

During the year the name of one nurse was removed from the Register of Nurses owing to the fact that she had been guilty of cruelty to a patient.

Amongst others, the following important resolutions have been recommended to the Council:

"That in view of the fact that the printed form announcing that a candidate has passed the Preliminary Examination is still regarded by some nurses in the light of a certificate, and that its possession enables them to pose as being partly trained, the practice of issuing these notices should cease, and that the fact of their having passed the examination should simply be notified to the Superintendent of the Asylum, and that a register be kept by the Registrar."

"That V.A.D. nurses who have had three years' nursing experience be permitted to complete their mental training in two years on the understanding that they pass both the Preliminary and the Final Examinations for the Nursing Certificate of the Medico-Psychological Association, allowing an interval of twelve months to elapse between the two examinations."

MAURICE CRAIG, *Chairman*.

J. G. PORTER PHILLIPS, *Secretary*.

Dr. PERCY SMITH inquired what had become of the certificate of the nurse who had been removed from the Register.

Dr. MILLER: It had not been actually issued.

The report was approved.



## REPORT OF THE REGISTRAR.

I have to report the following particulars concerning the recent Nursing Examinations:

Entries: 495 preliminary; 402 Final. Passed: 338 Preliminary (68 *per cent.*); 270 Final (67 *per cent.*; this includes 16, or nearly 8 *per cent.*, who passed with distinction.

Two Essays were received for Bronze Medal. These are now in the hands of the Examiners.

Six candidates entered for the Certificate in Psychological Medicine, and all passed the examination.

The Gaskell Prize has been awarded to Dr. James Walker; second, Dr. Monrad Krohn.

Dr. Eager wins the Bronze Medal, Dr. Norman Phillips being second.

I have an application from Stoneyettes for recognition. Dr. Oswald testifies as to its suitability.

It will be necessary to make some arrangements to get a special plate for the Certificate in Nursing of Defectives.

ALFRED MILLER,  
*Registrar.*

## THE PARLIAMENTARY COMMITTEE.

The Secretary read the report, which was approved:

Your Committee has met four times during the year. The chief subject that has engaged its attention has been the report of the English Lunacy Legislation Sub-committee. This report has since been adopted by the Association, and has been widely circulated, and your Committee has been informed by the Board of Control that a Bill has recently been drafted and is now before the Secretary of State providing for the treatment of incipient insanity. The newly-amended Rules in Lunacy in consonance with the views of your Committee are already in force. Sub-committees have been appointed in Scotland and Ireland to consider amendment of the Lunacy Acts in these countries. The Ministry of Health Bill has been under discussion, and a special committee has been appointed. It has been urged that the Association be represented on the Advisory Medical Committee to be formed under the Bill, also that due representation be similarly granted on the proposed Public Health Councils to be appointed in Ireland.

The Nurses' Registration Bills have been considered with a view of safeguarding the interests of mental nurses, and of obtaining adequate representation on the governing Council. A special committee has been appointed for this measure also. The Asylums Officers' Superannuation Act of 1909 has been discussed in its application of Sect. 4 (a), and an endeavour is being made to secure an amendment in regard to gratuities for dependents of contributors who are under pensionable age.

Application has been made to the Home Secretary for amendment of the Asylums and Certified Institutions (Officers' Pensions) Act of 1918, to place officers and servants of institutions for mental defectives in the first class for pensions.

The desire for simplification of the forms for certificates of disability of soldiers and sailors required from asylum superintendents has been impressed upon the Minister of Pensions.

The scope of the Medical Parliamentary Committee has been approved, and a member of the Association has been appointed on that Committee.

H. WOLSELEY LEWIS, *Chairman*,  
R. H. COLE, *Secretary*.

## THE BOARD OF CONTROL AND THE MINISTRY OF HEALTH.

Dr. J. G. SOUTAR said that certain matters had been dealt with by the Council at their meeting that morning, and he desired to move the following resolution:

"That a deputation be appointed to place before the Minister of Health the opinion of the Medico-Psychological Association that all matters concerning the care of the insane in England and Wales should as soon as possible be brought within the authority of the Ministry of Health; and that the Board of Control, whose sympathetic experience and encouragement in all matters concerning the welfare of the insane has been so valuable, be maintained for the department.

He said it was felt that their branch of medical practice, which was so important in its relationship to the health of the community, should not be left outside the Ministry of Health. Unfortunately, in the past, it had been the lot of their special work to be left lagging behind that of general medicine. Their work had a most important bearing on the health of the general community, and they desired it should be as early as possible recognised as a matter which should come within the Ministry of Health, which was intended to co-ordinate all matters concerning the health of the community. There was another reason. They all recognised that co-ordination ought to exist in what they might call the asylum services generally. They felt it was preferable that the co-ordinating body should be within a government department specially constituted to deal with the health of the whole community, rather than left to some self-appointed and self-created body which was inclined to consider asylum administration altogether from a lay point of view, and to eliminate the medical element from what are really medical institutions. They desired, instead of any such body claiming to be the co-ordinating body, that they should come under the Ministry of Health, which would be necessarily more sympathetic to the view that medical knowledge must pervade all matters of asylum management. In regard to the part of the resolution which had reference to the Board of Control, all of them who had had experience had seen for a long time past that they had maintained a most sympathetic attitude towards ideas of progress and advancement in dealing with matters concerning the insane. Deputations from the Association had been sent to them again and again, and they had met with most sympathetic encouragement in the evolutionary proposals made for the treatment and the care of the insane; that was becoming more and more a medical and less and less a legal matter (applause). The experience of the members of the Board of Control was vast; no other body that they could conceive of had such experience of the needs of the insane, or of the medical officers and staffs who had to look after the patients. It would be a disaster if that experienced and sympathetic body should be scrapped and some new body established when the administration of lunacy passed into the hands of the Ministry of Health. They therefore proposed to bring to the notice of the Ministry their appreciation of that body, and their desire that it should continue to be an important element in the Ministry of Health. (Applause.)

Dr. MILLER seconded.

Dr. EDWARDS was in favour of the resolution but thought the two matters should be dealt with separately.

Dr. SOUTAR thought the clause dealing with the Board of Control was most important, and he saw nothing invidious in mentioning their desire to retain that particular body in a department of the Ministry of Health. It was an important point with a larger bearing than appeared on the surface. There was undoubtedly a feeling in certain places that the Board of Control should be scrapped and some new body instituted. "We have had experience of the Board and know its value and I think we ought to say so." (Applause.)

Dr. BOWER thought if they did not say so it might be inferred they did not want to retain it.

Dr. SHAW BOLTON said it was not fully realised how much it was desired by some members of asylum committees to scrap the Board of Control. The chief object in the formation of the National Federation was to form mental hospitals which were free from the Board of Control. That would be most disastrous, and he was consequently strongly in favour of Dr. Soutar's resolution.

Dr. FOTHERGILL asked if the inclusion in the Ministry of Health would include borderland conditions?

Dr. SOUTAR said they would rather not make special reference to borderland conditions; the whole question of what constituted mental disease would be considered by the Ministry, and their Council thought it best to deal with general principles only in the resolution.

The resolution was carried unanimously.

Dr. SOUTAR proposed that a copy of the resolution should be forwarded to Dr. Addison, with a request that he would receive a deputation, and that it should be left to the President, Treasurer and Secretary to appoint the members of the deputation.

This was agreed to.

## THE TRAINING OF MENTAL NURSES.

Dr. ROBERTSON said he had been asked by the Council to bring forward a resolution dealing with the training of mental nurses, and the number of asylums in which they required to serve before being eligible to go up for examination. At present, according to the laws of the Association, this training might be taken in not more than two separate asylums. The Council proposed that in future the whole of the three years' course of training should be taken in one asylum. It was appropriate to bring it up at that meeting for two reasons. Twenty-six years ago it was possible for candidates to take their training at as many asylums as they cared to go to. Twenty-six years ago at the last meeting at York it was proposed and carried that they should only be allowed to take this training at two asylums. He thought they should now endeavour to insist on having the training entirely in one institution, and thus come into line with the trained hospital nurses. For mental nursing two different qualifications were required. In the first place the candidate must be a skilled nurse who knew how to care for sick people and to look after mentally deranged people. It was exceedingly important he or she should have this technical knowledge. But, in the second place, it was exceedingly important that those who looked after the mentally sick should also be people of good character—persons upon whom they could rely. He ventured to say the character of a mental nurse was often more important than the technical training. He would much rather have a person as a mental nurse on whom he could thoroughly depend that she would do all she could for the welfare of the patient under her charge. Of what use was technical knowledge if they could not rely on it being put into operation? A person without character, although she had technical knowledge of nursing, was most unreliable. The only way in which they could satisfy themselves as to the character of nurses or as to attainments was by keeping them under observation. A period of training which enabled them to take it in two institutions did not enable them to test character so well as under the scheme he proposed. It very often happened if a nurse had been in an institution and got into trouble by making mistakes she left it and went on to another, where she was able to hold on for some months and in due time she got her certificate. On the other hand, if she could only get her certificate by remaining in one institution three years, under the eyes of the matron or the superintendent, if she did that and passed the test that was all they could ask. He moved—"That in future the three years' course of training for nurses applying for a certificate of proficiency shall be taken in one mental hospital in place of 'not more than two mental hospitals.'"

Dr. OSWALD seconded. He asked that when the final results were published there should be indicated the percentage who obtained their certificates in English institutions and in Scottish and Irish. He had taken the trouble to analyse the list of those who passed the November examination, and he thought that over 60 *per cent.* were from Scottish asylums. He took the resolution to mean that the nurse must have been three years in the hospital from which she went up for examination.

Dr. ROBERTSON: She may be in any hospital she likes, but she must be three years in the one from which she gets her certificate.

Dr. EDWARDS said it must be recognised in fairness to those already under training that this would refer to the future and not to those now training.

Dr. SOUTAR: Certainly.

Dr. MENZIES opposed the proposal, which he regarded as retrograde. He hoped the next improvement would be to allow services in as many asylums as a candidate desired. To suggest one asylum for training was to throw an unmerited stigma on the superintendent of the former asylum by saying that the superintendent of the second asylum was a better judge and had more discriminating power. He thought if the superintendent could not judge in six or nine months or a year the character of a nurse, especially one supposed to be a senior nurse who had had some training in another asylum, then he was not able to give any certificate of character at all. He was one of those who agreed that general hospital training was desirable in asylum nurses, but he thought the one-hospital rule was due to jealousies between the various matrons. If hospitals were as far advanced as the Medico-Psychological Association, and had only a national certificate, there would

be no difficulty in a nurse going from one hospital to another. The idea of the Conciliation Report was that the Medico-Psychological Certificate should ultimately be scrapped, and that Management Boards of Asylums, together with the National Asylum Workers' Union, should gradually institute a nursing certificate in each asylum and slowly squeeze out a national certificate, while compelling the medical officers to teach what subjects the staff might select. That this would be a retrograde step the staff did not at present recognise, but that made it all the more incumbent upon the Medico-Psychological Association to oppose any such tendency. Compelling a nurse to serve all her training in one asylum would intensify this tendency, and therefore he opposed the motion.

Dr. SHAW BOLTON said that ever since he had been a superintendent he had systematically refused to take nurses from other institutions because they had so much to unlearn. He had had a couple of dozen who had come from other institutions who had certainly not been satisfactory nurses. Training was necessarily so different, method was necessarily so different, that for nurses to become really satisfactory it was much better to go through the full course of training in one institution. A nurse so trained was of much more use in an institution than if trained half and half. He did not know what alteration in the law was likely to take place, but if it was in the direction they were desiring the whole of the mental hospitals would approximate to the general hospitals. If so, he hoped no asylum would keep a nurse who had not been trained. It was perfectly true the Asylum Workers' Union wanted to oust their certificate, but at the same time it was true that not 20 *per cent.* of the mental asylum nurses were trained and got the certificate. In the West Riding something like 10 *per cent.* had got them; they should like 90 or even 100. If Dr. Menzies' idea were enforced they might be in a worse state. He would like to see training pressed to the fore, and the question of examination kept more in the background.

Dr. ROBERTSON denied that the proposal was a retrograde step. Dr. Menzies' hope that nurses might be able to take their training in more than two hospitals was a reversion to the state of affairs of twenty-six years ago. In reply to Dr. Menzies' other point, he denied that the proposal cast any slur or stigma on the superintendent at all. Every superintendent was capable more or less of judging character, but a certain amount of time was necessary for them to see the candidate at work, and nurses might be able to hold out for eighteen months and then give themselves away, but no certificate could be given until a certain practical test had been made. He re-read the resolution and explained that it was not retrospective.

The PRESIDENT put the motion and declared it carried by a majority.

#### SPECIAL COMMITTEE.

The SECRETARY read the report of the Special Committee.

#### RESOLUTION PASSED BY THE SPECIAL SUB-COMMITTEE OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION, JULY 4TH, 1919.

"It was decided that the constitution of the Medico-Psychological Association was such that it could not help the Asylum Workers' Association. The members of the Sub-committee were very sympathetic and were willing to help the Asylum Workers' Association in the way of affiliation or absorption by the Medico Psychological Association, but could not see their way to do anything in the matter. The Sub-committee recommended the Council to accept and administrate the Convalescent Fund of the Asylum Workers' Association if this fund can be handed over to the Medico-Psychological Association."

There were present at the above meeting Lieut.-Col. Keay, Lieut.-Col. Thomson, Major Worth, Dr. Shuttleworth, Dr. Powell, Secretary of the Asylum Workers' Association.

The PRESIDENT said the Sub-committee were very sympathetic and most anxious to help the Asylum Workers' Association, but to do so would involve an alteration in the constitution of the Association. The Secretary of the Asylum Workers' Association had undertaken to ascertain what could be done towards taking over the Convalescent Fund by the Medico-Psychological Association and administering it for them.



Col. THOMSON corroborated the President's remarks. They were very sorry the Asylum Workers' Association had come to an end, but certainly absorption or affiliation between them was impossible.

The SECRETARY reported that Mr. Bethell, who did some work for the Association at 11, Chandos Street, and who received £13 8s. a year, had asked that it be reconsidered. The Council suggest that the sum be increased to 25 guineas.

After discussion an amendment by Dr. SHAW BOLTON, seconded by Col. THOMSON, that the sum be £26, was carried.

The next business was fixing the dates of Annual, Quarterly, and Divisional Meetings of the Association and Quarterly Meetings of the Council. The following dates were suggested by the President: Tuesday, November 25th, 1919; Tuesday, February 24th, 1920; Tuesday, May 25th, 1920.

The Divisional Meetings are proposed as follows:

*South-Eastern Division.*—October 1st, 1919, at Elm Lodge, Clay Hill Lane, Enfield.

*Northern and Midland Division.*—October, 1919, North Riding Asylum, Clifton, York; April, 1920, Mental Hospital, Middlesbrough.

*South-Western Division.*—October 24th, 1919; April 24th, 1920.

*Scottish Division.*—November 21st, 1919; March 19th, 1920.

*Irish Division.*—November 6th, 1919, at Royal College of Physicians; April 1st, 1920; July 1st, 1920.

This was agreed to.

The following were submitted for election as members of the Association:

Peregrine Stephen Brackenbury Langton, M.R.C.S.Eng., L.R.C.P.Lond., M.B., B.S.Lond., Assistant Medical Officer, York City Asylum, Fulford, York. (Proposed by Drs. C. L. Hopkins, Bedford Pierce, and Stewart Adair.)

Henry Eggleston, M.B., B.S.Durh. Univ., Assistant Medical Officer, Brooke House, Clapton, E. 5. (Proposed by Drs. Gerald H. Johnston, R. H. Cole, and R. Worth.)

The PRESIDENT announced that Dr. Barkas had already been elected, and the other two candidates were unanimously elected.

#### "NOTES ON A CASE TREATED BY HYPNOTIC SUGGESTION."

Dr. JEFFREY read a paper bearing this title.

Dr. ROBERTSON congratulated Dr. Jeffrey on his excellent summary of an extremely interesting case. There was a time, a good many years ago, when he (Dr. Robertson) made use of hypnotism to a very large extent in the treatment of mental cases. He found that in all cases in which he attempted hypnosis those suffering from melancholia were the most difficult to hypnotise. Those suffering from acute mania were extremely suggestible, and so were very easily hypnotised. It was most difficult to get the attention of melancholic patients, and this being necessary to induce hypnosis, nothing was done. In this case, as Dr. Jeffrey had pointed out, the symptoms did not resemble those of ordinary melancholia. It was probably a case of what was known as anxiety neurosis; certainly the patient had the anxious feeling, dulness, introspection, self-depreciation, self-accusatory ideas, and defect of will-power they got in ordinary cases. But in this case he thought there was—he said it with all deference—very probably a very strong sexual element. The dream which was reported was one which, according to the Freudians, might be analysed symbolically sexual. Seeing that the patient was very anxious about her fiancé at that time he thought there could be very little doubt there was some sexual explanation. He did not think the dream was the cause of the illness; probably underlying it was the anxiety, which was merely brought to a head by the dream. It was a symptom of the patient's anxious condition. It was true the hypnotic condition dispelled the dream, but he wished Dr. Jeffrey had entered a little more fully into detail as to what he told the patient to explain the dream and to allay her anxiety. It was clear that what partly happened was this: the subconscious was deeply stirred up by the dream, and this produced an intense feeling of anxiety in the patient. One often found that melancholic patients were worse in the morning, and as the day wore on they

grew better. One wondered what was the explanation, and so did Dr. Clouston, but he found it was due to the fact that during sleep the subconscious was most active, so one was worse in the morning and by evening the subconscious became less active, and was repressed.

Dr. LADELL agreed that melancholic patients were practically impossible to hypnotise. He sometimes wondered if it would be wise to drug patients sufficiently to get them quieter, and then to superimpose hypnosis on the top of that. As regards Dr. Robertson's interpretation of the dream he thought his remarks showed how far Freud was astray. It was of course quite possible to put a sexual interpretation on the dream, but if Dr. Jeffrey had explained the sexual interpretation to the patient would the cure have been any more effective? The followers of Freud went wrong here; it was impossible to give a sexual interpretation to every dream; in fact, he seldom found that the sexual interpretation was the correct one. He had occasionally found jealousy came in, but the actual crude sexual interpretation seemed entirely unnecessary in every case.

Dr. EUSTACE congratulated Dr. Jeffrey on being able to induce hypnosis. They realised personal magnetism was needed to induce it, but all had not the power. He knew he could never induce it; he had tried and failed and would be very glad of details as to how it was induced.

Dr. JEFFREY said it was a case of anxiety neurosis. He entirely disagreed with the sexual explanation. Why should they try to correlate every circumstance of a case like this with a sexual meaning? He took particular care to try to find out if there was any sexual point which might have been raised in connection with this young lady. There was none, and the dream that he related had no sex connection at all. He induced hypnosis in the usual way. The first thing to do was to get the patient to detach her mind, and put it in a condition of absolute blank. To do that he sat quietly beside the patient and told her he was going to put her mind into a condition of blank, explaining that if the mind got into a condition of rest then they would have the condition of thinking normally again. He asked patients to give him their attention and think of nothing at all, and then suddenly he said the word "sleep," repeating it, and asking them to fix their eye on a shaded torch. When they found that they were becoming calm they would experience a feeling of detachment, and would then be able to listen quietly, and appreciate what was being said to them.

#### WELCOME TO FRENCH VISITOR.

Referring to the presence of M. le Docteur Henri Colin, the PRESIDENT said:

At this our Annual Meeting, occurring very appropriately at the time of the celebration of peace, we are honoured by the presence of a representative of the Medico-Psychological Society of Paris, Dr. Henri Colin, its Honorary Secretary. To our distinguished guest we extend a warm greeting and a hearty welcome, not only on account of his eminence as an alienist and of the fact that he represents at our Meeting the sister Society to which we are united by bonds of ever-growing esteem and affection, but if possible even more so because he stands for closer union and fellowship in all things with our brave and glorious ally the heroic and immortal France. (Loud applause.)

Dr. ROBERTSON endorsed the welcome, and added that he would like Dr. Colin to carry away the feeling that the Association were looking forward to the celebration in a few years of the centenary of the discovery of general paralysis of the insane by Dr. Boyle. He hoped that when their sister Association in Paris celebrated that event Dr. Colin would assure them that this Association would sympathetically consider any steps taken with that object—perhaps the greatest neurological discovery that had ever taken place. (Applause.)

#### DR. COLIN'S REPLY.

I most gratefully thank Col. Keay for his hearty welcome. It is for me a great pleasure to find myself here in this world-famous Retreat of the City of York.

Everybody knows the Retreat, at least by name, and for us Frenchmen, particularly, this name recalls the descriptions of our masters, Ferrus, Morel, Parchappe. It evokes also the souvenir of this admirable family of Tuke, who, without any other preparation than the goodness of their heart and their keen sense of justice, devoted themselves to the relieving of the invalids of the brain.

Our Pinel had begun in France in the year 1792; then in England William Tuke opened this house in 1796, and was followed by Samuel Tuke and Hack Tuke, who was the friend of many of my countrymen, and to whose dictionary I myself brought my modest contribution.

After William Tuke came Conolly and the no-restraint method now universally adopted, and the creation of these marvellous English asylums which have their equal in no other country.

We can boldly say that the treatment of the insane, and the medical and scientific study of mental diseases, was born and developed in France and in England, and this is the reason why some years ago I was amazed to hear the immoderate laudation given to the Germans in this special part of our medical art. We were only a few in France to protest against the hasty generalisation of German theorists relative to dementia præcox or manic-depressive insanity, and this, not in a spirit of low jealousy, but simply from a critical point of view, and because we knew that they were bringing us back from Germany under affected names, morbid states that had been recognised and well described in other countries.

In this branch, as they used to do in many other scientific branches, the Germans contented themselves to apply and to spread, without quoting the authors, the discoveries of others.

Let us hope that here also the war will have been a lesson for us—a hard lesson—and that before blindly admiring the theories of the other side of the Rhine we will simply read over again our own authors.

I bring here the respectful salute of my countrymen to the memory of the Tukes, whose work is so well continued by their most distinguished successor, the present superintendent of the Retreat, Dr. Bedford Pierce.

#### THE LUNCHEON.

Members were entertained to luncheon at The Retreat, Mr. Yeomans, of Sheffield, Chairman of the Committee of Management, presiding.

The PRESIDENT (Col. KEAY) thanked the Committee for their hospitality. In a humorous speech he explained that the Association was practically an Irish Association, and between Irishmen and Yorkshiremen there were many points of similarity. There was their love for constituted authority; their love of law and order; their antipathy to any violent methods of any kind, and their tolerance of those who differed from them in discussion. (Laughter.) This being so, it was natural that the Committee of the Retreat should welcome them there that day, as they were, in point of fact, the Medico-Psychological Irish Association. (Laughter.) They therefore expected to receive the kind of hospitality they had, and they showed it by coming to the Retreat for their new President, a gentleman who, if not an Irishman, could not help it. They had admired the Committee's splendid hospital, with its historic associations and its world-wide reputation for all that was good in the treatment of the insane. (Applause.)

The CHAIRMAN said the Committee appreciated the kind words which had been said about their institution. It was a pleasure to entertain the Association. It was not the first time they had visited York; he remembered the last occasion, when their Medical Superintendent, Dr. Baker, was President for the year. He remembered that his predecessor in the chairmanship of the Retreat took the opportunity of urging improvements in the status and the raising of the standard of education, and encouraging a higher type of woman to engage in the nursing of the insane. He believed that idea had permeated the asylum world, and to-day, though they still had a nursing question, it was of a very different character. It was a special pleasure to the Committee to welcome them, because, in honouring Dr. Bedford Pierce, they were in some sense honouring the Retreat. Perhaps he might remind them that the Retreat was opened in 1796, and they must not, therefore, expect to find it in some respects as a building altogether up-to-date. But they had endeavoured to preserve the homely character and domesticity of the institution, which had always been a feature of The Retreat. It was founded by William Tuke, and was the first asylum in England which was established on humane lines; at the same time M. Pinel, of Paris, independently carried out similar reforms at the Bicêtre. (Applause.)

Members subsequently inspected portions of the building, and viewed with great interest the archives and other historic psychiatric treasures of the Committee.

## AFTERNOON SESSION.—JULY 22ND.

## THANKS TO RETIRING OFFICERS.

Dr. PERCY SMITH proposed a vote of thanks to the retiring President and the officers of the Association. As regards Col. Keay, it was a pleasure to see the chair again filled by a new president. Col. Thomson loyally stepped into the breach and filled the chair for four years in succession, and now Col. Keay had occupied it for a normal year, and they offered their hearty thanks to him. The war had terminated, but Col. Keay was still in charge of a military hospital, and he had no doubt his military duties had been as efficiently carried out as his duties as President of the Association (Applause.) In leaving the chair they wished him every success and happiness in the future. (Applause.) "It is a pleasure," continued Dr. Smith, "that he is being succeeded by what I may call one of my old pupils. I mean that it was in 1891 that Dr. Bedford Pierce came as clinical assistant at Bethlem Hospital when I was in charge there. As to the other officers of the Association, I remember that when I was President I ventured to say that 'Presidents come and Presidents go, but the officers go on for ever,' and that but for the work of what may be called the permanent officers the work of the Association could not go on every year." Dr. Steen filled the gap as Secretary during the time Col. Collins was on military duty, and it was only during the last few weeks that Major Worth had succeeded Dr. Steen. He thought special thanks were due to Dr. Steen for the care he had taken of the affairs of the Association during the time he was Secretary. He was glad to say their friend the Treasurer, Dr. Chambers, was not retiring. It would be vividly in the memory of them all how long their Treasurer, Dr. Newington, held the post, and what an admirable example he set in the way of keeping the accounts, and they were all confident that in Dr. Chambers' hands the Association accounts would go on in the same admirable system. The Editors of the Journal during the war had had a most arduous task, partly due to the lack of material, and partly owing to the expense of paper and printing when they got the material, and the thanks of the Association were due to them for maintaining the Journal at such a level during the war. They had hinted that in consequence of the expense they might not get the Journal back to the size it used to be, but he hoped they would be able to restore it. Then there was their old friend the Registrar, who did an enormous amount of work. It was difficult to estimate how much work he did in connection with the registration of nurses. No one could grasp it who had not seen it; but no one could doubt their thanks were due to Dr. Miller. The Auditors were still going on; their posts involved a good deal of work before the annual meeting came on. Dr. Smith also expressed the thanks of the Association to the secretaries of the various Divisions, who had each accomplished most useful work.

Dr. EASTERBROOK seconded, remarking that, as the President had pointed out, their Treasurer, acting Editor, and the General Secretary and Registrar were all Irishmen—it was, in other words, an Irish Association (Laughter). He thought they would agree that as Dr. Smith represented the Association south of the Border, someone from the north of the Border should have the pleasure and honour of seconding this vote to their Irish confrères, and they would agree they had had a very peaceful year of Home Rule. (Laughter and applause.)

The resolution was unanimously agreed to.

The PRESIDENT returned thanks on behalf of his colleagues and himself for the kind words which had been spoken. He had now had a year as President, and he was more convinced than ever that it really did not matter what kind of a President they had. He could only reproach himself with being most inefficient, nothing else; it didn't matter in the very least whether he did any work or not, the work was carried on by their splendid permanent officers. It went like clockwork whatever the President might do or whatever might be his endeavours to upset it. He did not think it would be the desire of the officers that he should refer to them individually, but he was convinced they could not have a better set of officers than they had. The mantle of their old friend, Dr. Newington, as Treasurer, had fallen on shoulders more able to bear the strain, and their treasury was safe. In the Secretary they had one who was young and ambitious and with tremendous ideals, with push and energy, and there were great things before them. He would like to say one word about the Editors of the Journal. They had conducted it during



the war with credit to themselves and the Association. They had surmounted great difficulties and they would go on surmounting them because the acting Editor was an Irishman. He would say nothing about the Registrar, because he was another Irishman. "We are a modest people, and, like Yorkshiremen, the less said about it the better." It now only remained for him to die as gracefully as he could, but before doing so he had the satisfaction of handing over the affairs of the Association to one better able to look after them than he had been—he referred to Dr. Bedford Pierce. (Applause.) The Association was handing over the direction of its affairs—as far as he would be allowed to direct them—to a strong, resolute man who would perhaps hold his own among those officers of whom he had just been speaking. He had great pleasure in ornamenting Dr. Pierce with the badge of office in the certain knowledge that a year after this he would be as glad to retire as he (Col. Keay) was.

Having been invested with the Presidential insignia

Dr. PIERCE said he was very proud to wear the "blue riband" of the Association. He did not know that there was anything more pleasing in this world than to win the goodwill and appreciation of one's friends and colleagues. He had made no adventurous journeys in the realms of research; he had not even written a book, and he could not claim therefore any right to hold that position, except perhaps this, that he had always been, since he knew the Association, an ardent believer in it. He had always received the utmost kindness from the members; he had always had the greatest pleasure in attending the meetings and in doing what he could to help. It would therefore be a pleasure to pilot the Association this next year. He did it with the more confidence because they had heard of the efficiency of their permanent officials; but he also thought he could rely upon the support of all the members. "I hope they will check me when I may wander, uphold me where I may fail, and give me sympathy at all times." (Applause.)

#### PRESENTATION OF PRIZES.

The PRESIDENT announced that the Gaskell Prize and Gold Medal had been awarded to Dr. James Walker and the Bronze Medal to Dr. Eager. There had been no Divisional prizes. He believed the papers sent in were of exceptional excellence, and it was intended to give a second prize to two members of the Association whose papers approached close to those of the successful prize-winners.

The President mentioned that they had received a large number of letters expressing regret at inability to attend. Among them was a charming letter from Sir George Savage, a letter from Dr. Yellowlees, from Dr. Bevan Lewis, and from Dr. Ritti, of the corresponding association of Paris; also from Dr. René Semelaigne.

#### THE LATE DR. JOSEPH WIGLESWORTH.

Before beginning his address the President said his first duty was to refer to the death of one of the late Presidents, Dr. Joseph Wiglesworth. He did so with mingled feelings—a feeling of deep regret at the loss we had sustained, a feeling of pride that they had had among their members such a distinguished and able man, and of so high character. It was as long ago as 1883 that he won the prize for an essay the motto of which was unusual, though it seemed characteristic of his future work—"He shall be as a God to me who shall rightly divide and define." In it he dealt with certain states of melancholia attonita or acute dementia showing the inflammatory changes in motor cells. He was superintendent at Rainhill, where he spent nearly all his professional life. He was President in 1902 and his address was a distinguished and strikingly profound one on heredity. One fact of his life was known to many here, and to some intimately, because they were actually in the asylum when he was stabbed by a patient, the internal carotid artery being severed, and yet he walked a hundred yards afterwards holding the artery himself till he obtained assistance. He contributed numberless articles to our Journal, and did much to maintain the best traditions of our Association. He was an ornament to our profession, but he was by no means a one-sided man. Devoted to natural history he was especially interested in ornithology. After his resignation he lived in retirement at Winscombe and saw but few visitors. He travelled widely in pursuit of ornithology, and though persons around saw little of him he happened to hear from

a schoolboy from an adjoining school that he was frequently at Dr. Wigglesworth's house. The reason was the boy was devoted to ornithology, and this formed a common bond between them. His life was not without trouble. He had serious and painful administrative difficulties at his asylum, and grave disappointment at the end of his life by the loss of his only son in the war. They might consider him fortunate in that he did not suffer a long illness and the slow decline of faculties which is often such a sad feature of our common humanity. He was killed while exploring cliffs in North Devon in search of birds. They mourned his loss, and he was sure it would be the desire of all of them at that meeting to send a message of deep sympathy to Mrs. Wigglesworth at this time of great sorrow and loneliness.

#### PRESIDENTIAL ADDRESS.

The PRESIDENT then delivered his address on "Psychiatry a Hundred Years Ago: with Comments on the Problems of To-day" (see p. 219).

Dr. THOMSON moved a vote of thanks to the President for his address. He might be permitted to say they had had the kind of address they expected from him. It had been thoroughly sound, nothing adventurous or speculative, but with a sound outlook and consideration of the problems of psychiatry, both yesterday and to-day. Specially interested, of course, in the Retreat, Dr. Pierce had naturally looked back historically to the problems of years ago. He had brought out the striking fact that they were asked 3,000 years ago and 200 years ago very much the same problems as we were asked to-day. We seemed to grope about for a solution. Like Dr. Pierce, he was hopeful of an ultimate solution to many of them, and not to sink into the slough of feeling that the problems of insanity were unknown and unknowable. That was not the occasion to argue about the points which the President had raised; they had to thank him most sincerely for the wise and sound thought that he had placed before them in that address.

Dr. SOUTAR, seconding, said that what struck him most in the address was that the President had brought out in a very clear way how closely in touch their work was with every interest of the human race. Not only had they to treat illness, but they should recognise that the illnesses with which they had to deal were very much due to social conditions, over which they must first exercise control if they were going to stem the tide of mental disease. The President was not pessimistic, but he did not give full credit to the very definite advance made in the period under review. There was now established, largely under the influence of that Institution (The Retreat) among others—firmly established—the idea that the old methods of treatment were done with for ever. That was a definite step in advance at all events. As Dr. Bedford Pierce hinted, the next step they had to take was to deal with the earlier incipient cases. There was no reason for pessimism or questioning. We were further on than we were in the early years, and the President had taken a very material part in the progress that had been maintained, and the efforts of that Institution (the Retreat) were being continued under the present medical directorate. The paper was full of interest, and the way in which the President emphasized the necessity for research was of the greatest possible value. They were deeply indebted for the address, not only for its historical interest and for its philosophical tone, but also for its practical direction. (Applause.)

The vote was very heartily accorded, and was suitably acknowledged by the President.

#### GARDEN PARTY.

The Committee of "The Retreat" gave a garden party in the afternoon to the members and their friends, a large number of guests being invited to meet them.

#### THE DINNER.

The Annual Dinner was held at the Royal Station Hotel, York, on Tuesday evening, July 22nd, 1919. The President, Dr. Bedford Pierce, was in the chair, and among the guests were the Lord Mayor of York (Alderman Sir W. A. Forster Todd), the Sheriff (Alderman C. W. Shipley), the Dean of York (the Very Rev. Dr. W. Foxley Norris), Sir George Newman, K.C.B., Maj.-Gen. J. Thomson

C.B., Deputy Director of Medical Services, Northern Command, Col. Roche, R.A.F., Dr. C. H. Bond and Mr. A. H. Trevor, Lunacy Commissioners, M. le Docteur Henri Colin, Paris, Prof. T. Wardrop Griffiths, Leeds School of Medicine, Mr. G. W. Gostling, President, York Medical Society, Mr. Chas. Fernam, Chairman of the Retreat Committee, Mr. J. J. Hunt, Chairman of the Governors, Bootham Park Asylum, Mr. Arthur Rowntree, and others.

#### THE TOASTS.

##### "THE ROYAL MEDICAL SERVICES."

Dr. SOUTAR proposed "The Royal Medical Services." He said that while they might have chosen some one more fitted to propose this toast, it was hardly possible to ask one who had helped to make the wonderful record of those services, and therefore they had to fall back on one who had been an envious but admiring spectator. An onlooker like himself was quite incapable of making a speech worthy of the toast. But he had seen something of their ultimate achievements, and they were looking forward to the time when they would get a full record of the men and the measures whereby not only had the piteous cry for help from suffering, pain, and disablement been met beyond all previous experience, but whereby, in a way hitherto unthinkable, preventable disease had been prevented, and thereby man-power had been maintained and victory won. It was that which made possible the genius of our generals, the leadership of our officers, and the valour of our men. Because men did not die as in previous campaigns the shores of Great Britain were inviolate. That was due to the medical services. That was a great achievement, which even they as onlookers could perceive and admire. They were burning with desire, both as members of the medical profession and as citizens of the Empire, to express their profound and undying gratitude to those services—the men from the rural districts, the cities, our own countrymen; the men of the services from India, Canada, Australia, New Zealand—from everywhere where the British flag flies. They did not forget the United States, or anywhere where the sturdy strain of the British breed had gone. These all, by unity of purpose, solidarity of action, interchange of experience and knowledge, had not only effected this great achievement during the war, but had placed the human race under a deep obligation by pointing the way through which similar victories might be won over disease in civil life. (Applause.) "By their works ye shall know them," and in expressing their gratitude to those who, having faced difficulties in our country's cause, had come back to them, they sped a reverent thought to those who, having played their part, returned no more. (Applause.)

Maj.-Gen. THOMSON, C.B., responding, said the work of the R.A.M.C. in certain theatres of the war had been carried out in circumstances of extreme difficulty, but they could congratulate themselves in having overcome the difficulties. In France they held in check two diseases which had been the scourge of armies in the field in previous campaigns—enteric and dysentery. Enteric had been so curtailed by inoculation and improved sanitary arrangements that the admissions had been less than 100,000. With regard to dysentery the incidence had been greater, but even in that disease, by the strictest isolation and segregation of carriers with sanitary precautions they had managed so that the disease had never become epidemic, even during the latter part of the campaign when they were occupying ground which had been fouled by the enemy, because, judging by the prisoners of war, the disease must have been most prevalent. In addition they had new forms of disease to contend with, such as trench nephritis, trench fever, and trench foot, and last, but not least, so-called shell-shock. He thought it was a great mistake such a name was ever applied to this disablement, because it had given men all the glamour of being battle casualties, and furnished them with a pretext of getting admission to hospital whenever they felt disposed. Had the meeting been in Newcastle they would have been delighted to invite them to see their cases in the Northumberland Hospital. Many were cases of young soldiers who had improved considerably in hospital, though probably they would never be fit to serve in the ranks again. The worst cases were those of old soldiers who were drifting into the hospital. These men were highly excitable, intolerant of any form of discipline, and it was difficult to know how to deal with them. They

would be grateful for any advice in these cases. Maj.-Gen. Thomson acknowledged the deep debt the Army Medical Service were under to the Board of Control in placing at their disposal so many large asylums, fully equipped in every detail, which had proved invaluable to them as general hospitals. Many of the staffs, too, had joined the R.A.M.C., and had rendered yeoman service at home and abroad. In concluding, he welcomed the introduction of the scheme whereby men who were discharged from the army were treated in mental institutions instead of being treated as paupers. This had been a great boon, and had been highly appreciated by the relatives of these unfortunate men. (Applause.)

Col. ROCHE, R.A.F. also responded. He spoke of the great difficulty in organising the naval medical service, which was hopelessly understaffed at the beginning of the war, and said that although the position of naval surgeon and the conditions of life with the men on a ship presented enormous difficulties to the ordinary practitioners, yet they had been of immense help and assisted them to win through in the most extraordinary way. They of the permanent service had been most grateful for their help. As regards the flying service, the personnel at the start was very small. They were constantly confronted with many complicated conditions due to the extraordinary sacrifices and arduous tasks their fliers were called upon to deal with. Naturally new diseases under new conditions sprang up and they succeeded in dealing with them more or less—rather less than more—but there was undoubtedly a great deal of work still to be done. But it has got to be done in the future by a certain number of experts, because the work is too intricate and too big to tackle by the ordinary service of the military officer, who has many other things to think about besides research. They were looking forward to many experts, especially in their department of medical science, lending their aid in trying to classify the many diseases fliers were called upon to encounter. As to the future, nobody had anything to go upon as to what they would be required to do, but from what the general practitioner had done in the past they were confident they would not be lacking in granting any aid they needed. (Applause.)

“THE MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.”

Sir GEORGE NEWMAN, K.C.B., in submitting this toast, said the Association was established about the middle of last century. Its purpose had been two-fold: first, the amelioration of the condition of the insane, and secondly, the advancement of medical knowledge with regard to the ætiology of mental diseases. It was clear there were two groups of persons who were entitled to propose their health. One was the group of persons who were pundits on their particular malady; the other were the persons who could properly claim to be entirely ignorant of their particular malady. He was fortunate in not being acquainted with their particular malady, and he was fortunate in proposing the toast of the health of their Association in that place—the city of York—where in 1792 a great and courageous humanist, William Tuke, founded the York Retreat, and with others stamped out for ever and finished for ever as an ideal practice, the shackling of the insane. They were happy that evening in having a direct descendant of William Tuke dining at that table. He was fortunate in having to propose the toast and to couple with it the name of the distinguished man who was their President. He was also fortunate in the circumstances of the time in which their meeting was gathered at York. They were at the end of the war; they were hoping they were at the beginning of a period of reconstruction. There was no subject where reconstruction should bring better fruit to this country than in the cause for which that Association stood. They were met at a time when their own Association's Committee had produced a report which he and many others had read with great interest, edification and sympathy—a report which marked a great step onward in the progress of their practice and administration in regard to the treatment of those suffering from mental diseases; a report which he hoped at an early date would form the basis of a Bill in Parliament—a Bill which, he believed, would receive a large measure of support, and which would receive support, at all events, from the Minister whom he had the honour to represent that evening. There was another factor in the time in which they were met. That was the wide movement which was going on in the medical



profession in regard to the medical attitude to preventive medicine in relation to almost every branch of their profession, its science and its art. As they knew, it fell to his lot to be assessor of medical schools, and all over the country there was a movement in medical education which, he hoped, would lend its support to the cause for which that Association stood—for the reform of the treatment of mental disease. Lastly, there was incidentally the beginning of a Ministry of Health which, he hoped, would take its right share in this business. Might he tell them how he viewed the position which he thought preventive medicine should take in relation to mental disease? He thought it was the business of the Ministry of Health to endeavour to create and maintain the mental health and capacity of the nation just as much as to maintain their physical health. (Applause.) He drew no distinction whatever between their attitude towards the three diseases which were the scourge of our time—tuberculosis, venereal disease and influenza; the attitude which an enlightened Ministry of Health ought to have to those and their attitude to mental diseases. (Applause.) Secondly, they should view mental disease from the *preventive* standpoint. He thought the Ministry should say it was as much their business to prevent mental disease as to prevent any other. Thirdly, he thought their method of preventing it should be along lines which he should call physiological and psychological rather than any other. He should like to see this applied to all forms of mental disease and to all degrees, from the conditions of mental dulness and mental retardation to advanced insanity; from nervous diseases which are mental to mental diseases which are nervous. The whole group should come within the compass of the State, in the sense of the State taking an enlightened view of their preventability, and doing all they can to encourage newer, larger and more emancipated ideas with regard to mental diseases as a whole. At the Board of Education he had endeavoured to view the mental diseases of children more or less from that standpoint. He recognised that we had—though perhaps not very numerous, still, there were left in the population—persons of normal mentality. (Laughter.) What that fraction of the people is he did not venture to suggest. He was sure there was a large number—possibly 10, or 15, or even 20 *per cent.* in some districts—of children who were dull and retarded; suffering from psychoneurosis; a fourth group were aments, a fifth demented, and it seemed to him they ought to grapple with all groups nationally, and from the point of view of prevention. That meant they had got to tackle the cause. He remembered very well when he was bacteriologist at King's College for five or six years how impressed he was by the fact that around almost every organism there was a group of similar but atypical organisms. He noticed, too, in almost every epidemic they had not only the notified cases, the true type, but a zone of atypical disease kindred to it lying outside it. When he went to the Board of Education he had the same experience. We had in the schools a zone of children round the true mental defectives who were so dull and retarded that they could not be educated as normal children. It was the same with the deaf. They had a group who, though not totally deaf, were deaf enough not to get advantage from their education. It was the same with the blind. They had to start schools, not for the totally blind but for the partially blind, who lay immediately outside the zone of the totally blind. Was it not likely to be the same in some measure with the mental diseases? They had got to think not only of the true type certified for the asylum, but of the great mass of mental incapacity lying all around outside the typical cases of mental disease, and it was that great zone, as in other groups, that formed the problem of mental disease. The problem of typhoid was the problem of its first-cousins; it was the paratyphoids which gave them the trouble. It had not been the true, fixed, settled type, but the type kindred to it, similar, but not the true form. Personally he was satisfied that the State had got to consider not so much the acute fixed type, as to view the whole problem of mental disease *ab initio*, taking a possible standard of soundness as an ideal to seek after, so that they might become not only persons engaged in the treatment of advanced types, but that their labours might result in an increase in the total mental capacity of the State. That surely was the true view-point of the State with regard to mental disease. If that were so they had got to set to work in a larger way to consider the problem. They had got to think of causes—primary causes, predisposition and hereditary conditions, and also exciting causes, alcohol, venereal, and mental stress. This had got to be

considered positively rather than negatively by the State. All of them around that table could see what that meant. It meant that preventive medicine had got to begin with the difficult subject of eugenics. They had got to lay the foundation of good breeding if they were going to turn off the tap of mental disease. They had got to think in terms of childhood, not only in terms of acute and fixed types of the insanity of the asylums; they had got to preach the gospel of good breeding as the basis of national health. (Applause.) Secondly, they had got to work much more carefully on early diagnosis of incipient mental disease. There was a great region of unknown territory not yet mapped out. Thirdly, they must go a step further in regard to it and make some provision for its early and prompt treatment, sympathetic, physiological and psychological—something which should be early preventive medicine. They had a chance in England to-day, which their forefathers never had, of seeing with wider and larger vision the application of this method to mental disease in its early treatment and diagnosis. He was quite sure from what he saw in the medical schools it meant a new appreciation in every one of them of what mental disease meant. There must be a mental clinic in every medical school, so that no student should go out into medicine and medical practice until he possessed—he would not say profound learning on mental disease—but until he understood the profound importance of the relationship of psychology to all disease, and not only to fixed or final forms of insanity. They took the student now into an asylum and said he must be proficient in psychiatry in three months, but what understanding did he get from seeing a number of advanced cases? They were out on a big business when they grappled with mental disease from the preventive standpoint. He would not say it would mean the reconstruction of the medical curriculum, but it would mean that an understanding of medical psychology had got to form an integral part of the equipment of every medical man in future. Fourthly, they would require some new institutions—some outdoor clinics and indoor hospitals, for these early and at present perhaps unrecognised forms of mental disease. He did not want to see these places called by any name which would keep away patients from the door. But he was looking forward to the time when they would have—he hoped at no distant future—an “early-treatment clinic” for all conditions, for all grades of patients who wished to be treated, available for all classes of the population; open, sometimes for venereal diseases, sometimes for tuberculosis, sometimes for children’s maladies, sometimes for mental conditions, an early-treatment centre, in practice attached wherever possible, anchored wherever possible, to any well-equipped hospital. If they could get in every general hospital a larger and more liberal understanding of mental disease as such in relation to other forms of disease they would have started on the high road to reform. It was early treatment of disease; prompt, effective, competent, and adequate treatment they required. He knew this was not going to come to-morrow; but they had got to set their faces to the light with regard to mental disease and then he had no doubt of the future. He believed they had got to educate public opinion with regard to the grounds of mental capacity. For instance, it did not require much foresight to see that there was a psychology of the crowd, which was going to become very perilous in this country unless it was properly and psychologically handled. Again, during the war he had to go round the munition works as Chairman of the Health of the Munition Workers’ Committee, and he learned the lesson that there was a psychology of industry, and that you could get a higher output up to a certain period by studying it than you could without it. He was sure there was a psychology of mental disease, and if there was a psychology of the crowd, a psychology of the strike, of industry, and of disease, surely the time had more than come that they should say that there shall be increased attention given to some psychology in the medical curriculum. “These are the reasons,” added Sir George, “why I have come from London to accept the honourable task which your President has placed upon me of proposing your health. I do so with the greatest possible pleasure in my own name and in the name of the Minister of Health, who wished me to bring a message of goodwill. I hope he will be able, as I am sure he is willing, to do the utmost in his power in co-operation with the Board of Control to support your Bill which you now have in hand. The fact that he has nominated to-day one of your members to be a medical officer on his staff, representing for the first time in English Government mental disease, is, I think, some guarantee that he means

business. (Applause.) All the great conquests of the future in this country, of all modern advanced countries, lie in the realm of the human mind. 'Soundness of mind,' said Dr. Clouston, 'is the master key of all human endeavour and progress.' I humbly subscribe to those words, for they are my creed in preventive medicine in its relation to medical progress. (Applause.)

The PRESIDENT, in his reply, said they were glad to feel that the chief Medical Officer of the Ministry of Health would support them. Two committees of this Association had prepared reports which were unanimously adopted, and which emphasised the need for the establishment of hospitals for nervous disorders in which cases could be treated in their early undeveloped stages, and it was a great satisfaction to know that the Ministry of Health was with them. His thoughts during the previous speech had carried him back twenty-seven years to the first meeting of the Association he attended—to the annual dinner held in that room. Through all those long years he had had from the Association the utmost help and assistance. He would earnestly entreat all their young members to go to the meetings; they would learn something every time they went; they would pick up much from intercourse with their colleagues, and they would find their outlook would be widened, and the benefit they would obtain would be vastly more than they might think. At that time he was amazingly inexperienced: he had never been an assistant; he expected he was the last superintendent that would ever be appointed without having been an assistant medical officer. He was amazed to think the Committee ever had the courage to appoint him; in fact, there was an official protest against his appointment, and it was justified, for he had had no adequate experience. But there was one good point about it which was not generally adopted. He was appointed twelve months before it was necessary to take up the work. It gave him an opportunity to learn something. Through Dr. Hack Tuke's assistance he was appointed to Bethlem Hospital, and there, under Dr. Percy Smith, he got a sound insight into psychological practice at its best. He began his practical work in lunacy at a good school. After that he went to Edinburgh, where he was under Dr. Clouston, and where he was touched with the fire of that great man's enthusiasm, his extraordinary devotion and learning, and he saw a wonderful view of psychological medicine there. A corrective was present all the while he was there, for Dr. Robertson and Dr. Middlemass assisted to keep him in his place. (Laughter.) He learned from these gentlemen very much more than ever they knew, and he was glad to have an opportunity of thanking them. After that he went to Wakefield, where he saw scientific medicine under Dr. Bevan Lewis. Then he began his work. Twenty-seven happy years of life had gone, and, thinking over them, the first thing he would like to mention was the cordial relations which he had always had with those with whom he worked, more particularly the staff and the nurses, male and female. They who lived in institutions of that kind knew far more than the public the devoted services of the men and women who were engaged in nursing their patients. They were not properly appreciated by the public, and the friends of the patients did not know the services they rendered; the committees did not know; only the medical officers knew, and it had been an inspiration to see their work. It was difficult—it was appallingly difficult sometimes—and it was painful. He thought the words of the poet, speaking of humanity in general, certainly applied to something they all knew about, where he said:

"Here where men sit and hear each other groan;  
Where palsy shakes a few, sad, last grey hairs,  
Where youth grows pale, spectre thin, and dies,  
Where but to think is to be full of sorrow,  
And leaden-eyed despairs.  
Where beauty cannot keep her lustrous eyes,  
Or new love pine at them beyond to-morrow."

So that we were tempted in the earlier words to wish we could—

"Fade, far away, dissolve and quite forget  
The weariness, the fever and the fret."

It was sad, but there were compensations. There was the saving sense of humour. Some of the patients, as they knew, were most delightful. Dr. Pierce recounted several amusing stories, and concluded by saying he had found the Association



of the utmost benefit to him in the course of his life. He was proud to hold the position of President, and he cordially thanked Sir George Newman for the kind words he had used of him, and was delighted to think the Ministry of Health held such enlightened views. (Applause.)

"THE CITY OF YORK."

Mr. A. H. TREVOR, proposing "The City of York," said he was always pleased to come to York and to visit the Retreat, which had carried on its work uninterruptedly for a century, and Bootham Park, which was connected with his old and valued friend, just retired from the Commission, Sir Frederick Needham. No legal Commissioner could ever be treated with greater kindness and consideration than the speaker had been by Sir Frederick Needham. There was no one who took a more active interest in promoting the welfare of the insane. Mr. Trevor acknowledged the remarks of General Thomson with reference to the Board of Control and the arrangements they had assisted in making with regard to the utilisation of asylum accommodation to provide war hospitals. Whatever efforts the Board of Control made would have been futile, he said, had it not been for the extreme cordiality with which the scheme was taken up by every local authority, advised, as he knew they were advised, by their medical superintendents. He had been very pleased to hear the most interesting speech of Sir George Newman. They were now at what he hoped would be the beginning of certain improvements under the Lunacy Acts, and it was a matter for great hope when they knew the first medical officer appointed to the new Ministry of Health had so thorough a grasp of the problems with which he had to deal. It would be presumptuous for the speaker as a mere lawyer to say more, but it was a matter in which he as a lawyer on the Board of Control had taken great interest, and it was a satisfaction to know that some of the problems which they were particularly keen to get dealt with should be appreciated by the officers of the new Ministry. (Applause.)

The LORD MAYOR OF YORK (Sir W. A. FORSTER TODD) thanked Mr. Trevor for his references to the amenities of York and its asylum work. The irreverent had said that York was famed for its "lunatics and lollipops." (Laughter.) Certainly much of the prosperity was due to the sweetness of its manufactures, and which had delighted the palates of many children, and, he had no doubt, afforded scope for the professional attention of many doctors. With regard to the lunatics, it was true that they had in or near York the City Lunatic Asylum at Naburn (which he hoped some of the members would be able to visit—temporarily), the North Riding Asylum at Clifton, Bootham Park, the Pleasaunce, and last, but by no means least, the Retreat, which it was unnecessary for him to tell them was a landmark in the history of the treatment of the insane. For some years it had been under the most able and dignified care of their President, whom they in York are proud to count as a citizen. The York Corporation, like other corporations in the country, was concerned mainly now with solving the housing question, and dealing with the arrears of work in public health and other matters which the war has brought about. This meant that the rates had taken a leap up, but they had all become so accustomed to the expenditure of huge sums of money that the "dose," which would have been most unpleasantly received before the war, had been swallowed with scarcely a wry face in the city. (Applause.)

The DEAN OF YORK (Dr. FOXLEY NORRIS) also responded, and said that if that great concourse of experts could see as far as they ought to be able to see—(Laughter)—they would recognise in him something closely akin to themselves. For this reason: there hung in the Hall of the Royal College of Physicians five portraits of men who bore an honoured name, and who were all, he thought he was right in saying, either Treasurers or Presidents of the Royal College in their time. They were all mental physicians. They represented five generations of father to son and—they would forgive him being personal in this matter—they were all, he was proud to say, ancestors of his own—his uncle, his grandfather, his great grandfather, and his great great grandfather, and therefore he was more "tarnished" than Mr. Trevor suggested. When he told the company that the name of these ancestors was Monro he thought many of the company would recognise he was right when he made a very special effort to be present and take his humble part in these proceedings. He was proud to respond for the City of York. When he



asked himself why they should have chosen York for their meeting-place he found a multitude of reasons. Among them there was the reason that actuated everyone when they wanted to get away from all those things which ordinarily occupied them, from all possibility of being reminded of ordinary duties, and therefore they came to a county which was peculiarly sane, and a county which had been—at least till the last fortnight or so—well known for its sanity. There was another reason which appealed particularly to him why York should be attractive. He represented one side and the Lord Mayor represented another side of very ancient jurisdictions. He believed even at the present moment the Lord Mayor did not exercise any jurisdiction over the speaker's property, and that he could do what he liked and the Lord Mayor could not touch him so long as he was in the Dean's Park and on his own ground. (Laughter.) There was an ancient jurisdiction known as the Liberty of St. Peter which dated back to Edward III. Two years ago, when there was an idea of the military occupation of certain houses within the Liberty, he told the officer who came to inquire about it that it would be convenient to him if a certain house might be commandeered. The officer replied his instructions were that that was impossible, because it was in the Liberty of St. Peter. If, therefore, he was immune from the War Office and "Dora," he was also immune from the Lord Mayor. (Laughter.) The great building within that Liberty, which dominated the landscape when they got outside York, dominated the affections and loyalty of all people in York and Yorkshire. That great building stood in every sense for religion. He ventured with all diffidence to welcome them to York, because he represented the Minster, and the Minster represented religion. Personally he believed that if the country was to be what they all hoped it would be after the war, it would only be by those who represented their noble profession and those who represented his in the widest sense working shoulder to shoulder and hand in hand. He believed that the forces of science and the forces of religion probably came closer together in connection with their work than in connection with any other branch of science. He believed the day when they thought there was any sort of antagonism between science and religion was passing away, and he trusted that the day was coming when they who represented the religious side of things would take larger and wider views than in the past, and that the medical men would come nearer to the clergy than had been customary in days gone by. When they were both working for the highest welfare of humanity they would work together, and therefore they would succeed. (Applause.)

#### "YORKSHIRE MEDICINE."

Mr. ARTHUR ROWNTREE, proposing "Yorkshire Medicine," said it would be easy to go through a long list of men who had been famous in York and the county in connection with medicine. But he might just refer to two or three who were of special interest to some of them. They need only go back to Martin Lister, who must have been one of the first Fellows of the Royal Society in Charles II's reign. He seems to have turned his attention to other things, for he was spoken of as the first who noted with interest the piece of Roman military architecture that York possessed in the Multangular Tower. Then there were two surgeons at the York County Hospital, Drake and Atkinson, both better known on other grounds—Drake as the author of the famous *Eboracum*, and Atkinson as one of the founders of the Yorkshire Philosophical Society. Then, of course, there was Jonathan Hutchinson, who went out from the medical school in York to win fame in London. When some of them were boys the name of North, too, was a household word in York. Those in that room, as elsewhere, might be divided into two classes—the healers and the sufferers. The healers sometimes condemned the sufferers to sit in their armchairs and enjoy the fellowship of books in a way that they would not be able to enjoy them if they were allowed to go about their daily occupation. Thus he recalled the famous Dr. Slop. His biographer gave them a vivid description of the man which none could ever forget. He talked of his four feet of perpendicular height, his breadth, and "the sesquipedality of his belly, which might have done honour to a sergeant in the Horse Guards." In such reverence did they hold Dr. Slop in York that he believed they still retained in the archives of the Medical Society his immortal forceps. (Laughter.) He had recently been reading with great enjoyment the life of Lord Lister, whom he

claimed as a Yorkshireman—(Laughter)—for in the sixteenth century there were many Listers in Yorkshire, and a matter of two or three hundred years was insufficient to eradicate the Yorkshire strain from his blood. He was especially pleased to claim Lord Lister as a Yorkshireman because it seemed to him he stood so well for their profession, as he taught his students to make their progress guided by "unfettered truth and love unfeigned." (Applause.) He coupled the toast with the names of Dr. Wardrop Griffith and Mr. G. W. Gostling, the latter the President of the York Medical Society and a real healer, as he knew, and the former the Principal of the Leeds School of Medicine. He did it, full of local York patriotism, for he was one of those who still believed that his ancient city of York was made by nature and by man to be a University city. In the eighth century it was virtually a University city, and scholars were sent out from it to almost every part of Europe. When York was practically a University city in the eighth century, Leeds was still primeval forest. But the Fates, or the Furies, had gone against them, and to-day they dare not ask, "Can any good thing come out of Leeds?" They remembered in this connection two names among others—Sir Clifford Allbutt and Sir Berkeley Moynihan. They also remembered Dr. Wardrop Griffith, and he thought of him as representative of those hundreds of healers in this great county who in times of depression gave them back their confidence in themselves, as representative of the hundreds of men who spent their time in alleviating untold human suffering, and of the great procession of those men who tread the road of life in step with knowledge and wisdom because they held that great dictum of Pasteur, that in the field of observation chance only favours the mind that is prepared. (Applause.)

Dr. WARDROP GRIFFITH, in responding, said the subject of Yorkshire medicine was a very large and extensive one. He might be excused if he thought of it from three points of view: the Medical School at Leeds, the Medical School at Sheffield, and—the backbone of the profession—the practitioners all through Yorkshire. If he limited his subject to the Medical School at Leeds, it naturally divided itself, as most things did, into three parts—past, present and future. In regard to the past, distinguished names had been mentioned. In regard to the present, one distinguished name had been mentioned—Sir Berkeley Moynihan—and for the speaker to have had his name mentioned alongside those of Sir Clifford Allbutt and Sir Berkeley Moynihan was indeed an honour. Sir Clifford Allbutt was the man who in the past was associated with Leeds, and whose name they honoured most of all, not only for his scientific ability, but for his kindness of heart and charm of manner, which seemed to grow greater as he advanced in years. The speaker mentioned that when he went to Leeds in 1883 he was Sir Clifford's last house-physician, for he retired from the Staff of the Infirmary in 1884. Dr. Griffith outlined the later stages of Sir Clifford Allbutt's career, and said that when one considered how he had adorned the position of Professor of Physic at Cambridge University since 1891, then truly they might say this was the age of old men. But he was still young enough to preside at medical meetings, and to speak with all his old charm of manner and with his beautiful English which they all admired so much. As to the future, he had only to refer them to the most stimulating words which had fallen from Sir George Newman. The future of the medical profession as a teaching profession, was bound up to a great extent with the spirit of everything which had fallen from him. They had been considering of late certain alterations which might spring from what he regarded as one of the most remarkable documents that had ever appeared—Sir George Newman's "Report on Medical Education." If they could bring in a great many of his suggestions, while they retained the daily-bread side of teaching, then he ventured to think the future of medical education in this country would approximate more to the high ideal which Sir George had sketched out. (Applause.)

Mr. G. WILFRID GOSTLING said he regarded it as a very great honour to be coupled with the toast, and he accepted it as President of the York Medical Society. With reference to what Mr. Rowntree had said about a University for York, might he suggest that in the Palace of the Stuart Kings, the Museum, and the site of the exhibition they had a site for a University which, perhaps, under the Education Committee, might be realised in the future. York County Hospital, unfortunately, lost its Teaching School owing to the number of beds not being adequate. He very much regretted that the Governors and Trustees were not

far-sighted enough to increase the numbers of beds so that they could continue the School, for with Sir Jonathan Hutchinson and Mr. Jackson they had good reason to continue the School.

"THE GUESTS."

Dr. OSWALD said he had to propose the health of those who had accepted their hospitality, who had broken bread with them, and who were now their friends. It would be impossible to deal with them individually, but he must mention Dr. Henri Colin, of Paris. They honoured him not only for his own qualities—and they were many—not only for the eminence which he had attained in the specialty and in the general profession of medicine, but they honoured him as a son of France—(Applause)—France, rapidly healing of her wounds, relieved of her agony; France—the old but ever-chivalrous and honourable enemy of this country, and now her firm and enduring friend. Perhaps he should have said the old enemy of England, because, Scot as he was, he remembered she was never the enemy of Scotland; indeed, they cherished her memory as their ally against "perfidious Albion." (Laughter.) Referring to the presence of the Dean, he said they highly appreciated the connection between the Church and Medicine. They in the specialty valued its ministrations and knew how much it helped them in their work in dealing with one of the most grievous afflictions which God could put upon suffering people. As regards Sir George Newman, he hoped he would succeed in carrying into actual practice the ideas which he had so eloquently expressed.

He wished to say how much they appreciated the support given them in their difficult work by the general practitioners, how much they valued their sympathy and help. In regard to the lay guests, he would like specially to refer to the presence of Mr. Tuke, one of the lineal descendants of William Tuke, who founded the Retreat, the Mecca of the mental physician. It was said that "science knows no frontier," and they hoped that the presence of Dr. Colin would lead to a continuance of the friendship and intimacy between their Association and the corresponding societies in France.

Dr. HENRI COLIN, in responding, thanked the members of the Association for the honour done to the Société Médico-Psychologique of Paris by the invitation to their meeting. They would excuse him if he read his speech, because it was so long since he had the opportunity of speaking English that he was not over-confident. Would they allow him to express the sentiments of deep gratitude that the French felt towards them? They would never forget that England was the first to stand by them; they would never forget that without the British fleet the war would have been lost, just as would have been the case if during more than two years the French soldiers had not opposed a stubborn resistance to German barbarism. This would have been a universal calamity, for this war was not a war of one nation against another nation; it was a superhuman fight in order to save what they felt were the most noble things on earth—justice and the freedom and rights of mankind. (Applause.) Two great democracies—England and France—rose to defend these imprescriptible rights, and these two democracies were well made to understand and to assist each other. Both of them had always fought in order to insure to men a greater amount of liberty and welfare; both of them, for this one object, had made a revolution. Was it not a marvellous thing that, even when France and England fought against each other, they had not for that ceased to keep a mutual esteem and admiration one for the other? British philosophers, scientific men, were the friends of French encyclopædists of the eighteenth century who prepared the great Revolution. Even when they were adversaries the French spoke of them with admiration. "Ces tiers Anglais"—"these proud English"—said Mirabeau. The key of this mutual esteem was to be found, he believed, in the deep sense of justice and in the keen appreciation of individual liberty which is to be found in their two nations. An example will enable him to make this thought quite clear. He did not believe that an affair like the Dreyfus case could have awakened the formidable and tremendous movement which they remembered except in a democracy like theirs, or in a democracy like that of England. This indignation, which made a whole nation rise because an unmerited wrong had been caused to one sole man, would not have been understood in Germany, where everything was submitted to a so-called State



interest, as if injustice and evil could be of any use to the State. One of the facts that struck him most during the war was that in France the incomparable victories of a Napoleon had not prevented the thinking and liberal classes to protest against his imperialism and despotism. This never took place in Germany, where everybody lightly accepted the war and the worst atrocities if some profit could be had in that way. One was amazed to think that a country which has given birth to such a great number of illustrious thinkers and philosophers could have been brought down to have such childish and at the same time such monstrous conceptions. Now that their soldiers had come in innumerable forces on the soil of France, he hoped they would understand the soul and they would love his country; they had been able to know it closely and not merely to get a false idea of it by what they saw of a cosmopolitan part of Paris, which is not the real Paris. Just as it seemed to him impossible for one to come to England to know the English, their habits, their homes, and not to love and admire England, it seemed to him impossible to come to France and know France without loving and admiring France. He could not refrain from expressing sentiments which he felt so deeply, and he thought he could not find a better place to do so than at that meeting of psychologists, accustomed to deal with the various manifestations of mind and the greatly diversified feelings of human nature. That was the reason why meetings like that were of such great utility. He hoped that in their turn they would come and take part in their Congress, especially if their next Congress was held, as they hoped, in their dear city of Strasbourg, now at last liberated. (Loud applause.)

During the evening a programme of piano and violin selections was given by Mr. W. Baines and Miss Madge Tuff, Mr. Frank Straw contributing songs.

#### MORNING SESSION.—WEDNESDAY, JULY 23RD.

Held at the Bishops' Room, St. William's College, York, Dr. Bedford Pierce, President, in the chair.

##### PAPERS.

Dr. G. L. BRUNTON read a paper entitled "Notes on the Cytology of the Cerebro-spinal Fluid."

The PRESIDENT said the paper represented an immense amount of good work. It was the record of original research undertaken by Dr. Brunton, and was, he believed, an abstract of a fuller paper which he prepared for his M.D. thesis at Edinburgh, where it obtained very marked distinction. A technical paper of that character was a rather difficult thing to discuss. Many of them were almost exclusively concerned with clinical medicine and their knowledge of pathology was not great, but they had the pleasure of the presence with them of Capt. Latham, a pathologist from New South Wales, and he hoped he would take part in the discussion.

Dr ROBERTSON said he thought Dr. Brunton's observations were extremely important from the clinical point of view; it was one of those instances where they obtained very great help from laboratory work. Its chief reference was the diagnosis of general paralysis and differential diagnosis of other conditions somewhat related to it. General paralysis was the most terrible disease with which man was afflicted, and its diagnosis practically meant sentencing a man to death, and therefore should not be done unless every precaution had been taken. The discovery of several laboratory tests for general paralysis enabled them to diagnose this disease with greater certitude—in fact, he thought no disease could be diagnosed so certainly. At the same time there were some doubtful cases, and it was from these cases they derived help. With regard to diagnosis by these cells he believed there was absolutely no specific test for general paralysis in respect of the presence of these cells, or the proportion in which they were to be found. They found them apparently in many different conditions; they found them in all syphilitic conditions, and he did not think there was any definite conclusion to come to in regard to them. He believed the lattice-cell was merely a degenerated cell; it looked as if the cell were become fatty, and he thought no very special significance could be attached to it. Dr. Muirhead and Dr. Henderson found all these cells even in the fluid of pleural effusion and tubercular meningitis. Though it was a great advantage to have this examination of the cells, and in the



majority of cases the help obtained was very great and confirmed one's diagnosis of general paralysis, still, in the extremely doubtful cases he did not know that one could come to any definite conclusion either by the presence or the percentage of the cells. With their increased knowledge of general paralysis they realised that syphilitic conditions—chronic syphilitic lesions—gradually passed into conditions of incurability, and the phenomena they presented resembled general paralysis very closely.

Capt. LATHAM expressed his deep sense of gratitude to the reader of the paper. He said it had been the custom in New South Wales to examine every case by Wassermann reaction, and if there was no result the cerebro-spinal fluid was sent down to be examined. The method employed was the same as that used ordinarily in counting white blood-corpuscles, and they found this worked very well, and in the majority of cases the results were as the lecturer stated. In some cases it was valuable in examining cases of insanity due to lead poisoning, which was rather frequent in Brisbane among children, who were much given to scraping the powder paint from the verandahs. If not treated early by lumbar puncture it meant total blindness. He was once asked to see a child in hospital, suffering from encephalitis of unknown origin. He examined it and found very few cells but an excess of globulin. A lot of very important work was done in their laboratory in connection with the treatment of general paralysis by injecting salvarsan, and he thought it was true to say that a large number of these cases regularly went out of the hospital and then came back again, and the question remained how far were they cases of general paralysis? It was impossible at times to tell cases of general paralysis from the peculiar conditions of the spinal fluid. They had done several hundred experiments, and they found they very seldom got an increase of cells without an increase of globulin. In regard to the cell-count, in a certain number of cases it was found that the cell-count decreased as a person went under treatment with intra-venous salvarsan and the subsequent injection. Capt. Latham mentioned, as showing the care taken with these cases, that they encouraged inquiry among the friends of the patients, and got to know many wives and children on whom they found the definite stigmata. A great many families of patients treated in mental hospitals were affected and did not know it, and they then had the opportunity of getting treatment through the energy of the medical officer in charge of the case.

Dr. EDWARDS said the thing that would come home to most of them with a note of wonder was what Dr. Robertson had remarked about the question of lymphocytes in the cerebro-spinal fluid not being pathognomonic of general paralysis. In recent years most of them had made this test in association with the Wassermann reaction, and had made a positive diagnosis on the result. He remembered a man transferred to his care who had no clinical trace of the disease; he was apparently normal, so much so that the family thought a mistake had been made. An eminent pathologist had examined the cerebro-spinal fluid a year earlier and had found lymphocytes. He asked him to renew the test, but he was assured in reply that there was not the slightest use in doing so as the former examination had entirely settled the prognosis. The subsequent history proved that he was right. Most of them as clinical physicians had never given thought as to the type of cells; but, in future, he would get the varieties of cells examined, and bear in mind Dr. Brunton's results. In conclusion he did not think that it had been generally realised what Dr. Robertson had told them of the difference between the various parasyphilitic conditions.

The PRESIDENT said that one remark of Dr. Latham's showed them they could learn something from Australia. Neighbouring asylums in England were not able to join together for pathological investigation. The auditors would not permit it. With the very full system of co-ordination between the institutions in New South Wales their pathological work could be done easily and efficiently. Here every institution had to do what it could by itself; the smaller ones were not able to join with others in co-operative work of this kind.

Dr. BRUNTON thanked the members for the favourable reception they had given to his paper.

#### ANALYSIS OF CASES OF MENTAL DEFECT.

Dr. J. E. MIDDLEMISS read a paper entitled "An Analysis of Two Hundred Cases of Mental Defect."

The PRESIDENT said they would prefer to read the paper quietly before discussing it, but he would like to say he thought Leeds was to be congratulated on possessing a medical officer who took such pains with the cases of mental defect with which he had to deal.

Col. DAWSON associated himself with the President's remarks and said they would learn much from the paper when they had been able to study it quietly.

Dr. EDWARDS said the references to the stigmata of degeneracy were full of interest, and he wondered if Dr. Middlemiss had noticed any large proportion of the condition of polydactylism, web-finger or other abnormalities. In his own personal observation he had often noticed the conformation of the hand was of a simian type in people who developed dementia præcox.

Dr. MIDDLEMISS said he did not recall many cases of actual polydactylism. He had met cases where there was disparity in two or three fingers, but the toes were approximately the same length. He did know that he had noticed hands absolutely comparable to the dementia præcox type of hand; he had met them long and flat. He was convinced anomalies of the hand were properly described as stigmatic.

#### WAR FATIGUE AS A CAUSE OF GENERAL PARALYSIS.

Dr. HENRI COLIN contributed a paper on "The Influence of War Fatigue on General Paralysis." He summarised his paper as follows:

(1) The question of the reform of general paralysis in the Army in France has gone through two phases. It is only since July, 1917, that the great majority of psychologists have recognised that in the ætiology of Bayle's disease the influence of the war was much greater than had been supposed to be the case.

(2) The observations which had been gathered in the military section of the Villejuif Asylum, which is placed under my direction, have confirmed us in that conviction. Especially the rôle of all kinds of fatigue, toxi-infection, emotion, etc., has seemed to us to play a most real part in the exceptional rapidity of the evolution of general paralysis in the fighting units.

(3) The most recent services of general pathology explain the rôle. General paralysis is due to a hypersensibility of the nervous tissue. It is also, clinically speaking, a malady due to exhaustion. This notion of exhaustion enables us to do the synthesis of the observed cases.

The PRESIDENT, congratulating Dr. Colin, said he had raised many serious problems which were of great importance in this country. The question of the extreme rapidity of acceleration of general paralysis arising from war strain was one of which he personally had not had much experience, but there were service members present who would be able to say whether the observations in Paris corresponded to those in England. He felt that the whole question of the ætiology of general paralysis was at present in a most unsatisfactory position. The London school had always held the doctrine, "No syphilis, no general paralysis," and it had gradually gained ground until it was almost an accepted dogma. He had always had doubts of its truth. In a large percentage of cases spirochætes can be found in the cortex of the brain, but the evidence is not satisfactorily demonstrated. He had asked pathologists about them and they told him there was an immense number. They were found in everybody's mouths in conditions of health, and the differentiation was by no means satisfactorily established, nor their life-history particularly well worked out. He was not aware that the micro-organism which was found in the brains of sufferers from general paralysis was sufficiently identified as the spirochæte of syphilis. If syphilis was the basis of general paralysis, why was it they never found the tertiary symptoms in general paralysis? It was most unusual to find well-known syphilitic stigmata in persons who died of general paralysis. He had been much struck by the facts which Dr. Colin brought out as to the causation of general paralysis—emotion, accident, and so on. We had a great deal yet to learn of the part which the micro-organism played in its genesis.

Col. DAWSON congratulated M. Colin on an extremely interesting paper which raised many points. Owing to his position as Mental Specialist to the Irish Command and the special medical board which dealt with Ireland, Col. Dawson said he had seen a certain number of cases caused by war conditions. These cases had not presented any very marked peculiarities. Of course he had no

observed them from day to day, but his impression was that they were not of a specially rapid type. General paralysis in Ireland was almost a rarity; most of the country places in Ireland were absolutely free from venereal disease, so comparatively few of the Irish soldiers had been syphilised in the first instance whatever may have happened when they were abroad. As regards the ætiology of general paralysis, personally he believed syphilis was the essential factor, but so small a number of them developed general paralysis that there must be other influences giving rise to it. Fatigue must have played a leading part, combined with emotion and toxins. He would like to know if alcoholism played a leading part in Dr. Colin's cases, because he had thought that in civil life alcoholism had played a leading part on nervous systems weakened by syphilitic virus. Many of Dr. Colin's colleagues laid great emphasis upon the influence of alcohol. If one admitted, as he thought they must admit, that comparatively few syphilised people got general paralysis, then it followed that there must be a number who would not get it if it were not for the stress and strain and toxins brought to bear upon them. That being so it was obviously unjust to penalise men who developed it, by reducing their pensions. Personally, he thought a man who, so far as they could tell, was sound when he went out, and who, as a result of service, had developed general paralysis, was due for a full pension. With regard to the question of the absence of tertiary signs, which was the rule in general paralysis if not invariably so, he did not think there was much in that, because they found the same thing in other conditions which were toxic—for instance, in alcoholic diseases of the nervous system. They did not get cirrhosis of the liver in asylums although in many cases the insanity was due to alcoholic indulgence.

Dr. ROBERTSON added his thanks to Dr. Colin for his masterly summary of the ætiology of general paralysis. He believed the procedure in this country in regard to the pensions of those suffering from general paralysis was very largely founded on the work done by Dr. Colin. His observations on special cases of general paralysis confirmed those presented by Dr. Colin. They had been impressed at Morningside by the rapid course of general paralysis during the war. Dr. Colin had raised the whole question of the ætiology. His own inclination was rather against the hypothesis that there were accessory factors, but his belief had been somewhat shaken by what Dr. Colin had said and the evidence he had produced. He thought they might agree that the statement, "No syphilis, no general paralysis," was absolutely true. He did not think any statement had been made which refuted it. The point was, Why should so few who suffered from syphilis develop general paralysis and so many escape? In the first place, general paralysis was a disease which started very late; he only knew three cases in which it started within three years of the infection. The best explanation of this was that general paralysis must be looked upon as a hypersensitive reaction. If this were so they must look upon it as a condition in which there was re-invasion of the brain by spirochætes some years after infection—generally five years.

The PRESIDENT: Where is the micro-organism all the while?

Dr. ROBERTSON said the brain was invaded in the secondary stage, and then there was a latent period during which people were supposed to be cured. In this stage, where there were no apparent symptoms, they knew by the Wassermann reaction it was merely a latent condition, and then for some reason—it might be alcoholism—the spirochæte became active and invaded the brain a second time. It was quite true, as everyone realised, that they seldom got cases of general paralysis which had had tertiary lesions, but there had been numbers reported and he had seen certain cases. Seeing that general paralysis did not develop, on an average, till at least five years after syphilis, and a very large number of those who suffered from it recovered—Boas made observations in 2,000 cases of syphilitics and found in two-thirds of the cases negative reaction, therefore they still had one-third suffering from latent syphilis—they might say they had 9 to 15 *per cent.* of the cases of latent syphilis developing general paralysis. That was a very large percentage, but if they compared it with the number of lesions in other diseases—take diphtheria and diphtheritic paralysis—it did not amount to more than 12 *per cent.* of the cases in which it developed. No one dragged in accessory factors as to why one suffered from diphtheritic paralysis. Why should there be any extra factor in the syphilis cases? He did not think it at all necessary there should be an accessory factor called for. There was one point connected with the ætiology



of general paralysis worth reference: he thought the amount which developed in women and children was not relatively the same proportion as developed in men. The amount of general paralysis among women is comparatively small, and they knew a very large number of children suffered from inherited syphilis, especially amongst imbeciles, but the amount of general paralysis that occurred in young children was very small. It was only in 1877 that Dr. Clouston described his first case of juvenile general paralysis. It was an extraordinary thing there should be a lesser number developing general paralysis in children, and it was possible they were not subjected to the accessory factors—as Dr. Colin and others stated—of accident and alcoholism. That might be the explanation. It had been a great pleasure to have Dr. Colin to present them with such a masterly paper, and as an associate member of the French Society it gave him additional pleasure to thank him for his address.

Dr. Ross said that in the later years of the war he was posted to a northern war hospital for general paralytics. He was present at the time of their reception, and having charge of the refractory wards he got nearly all the general paralytics. There was a very large number of young men, twenty-six years of age or thereabouts, many of whom had a history of recent syphilis—quite a number since the war began—and therefore there could be no doubt about the acceleration of the disease. A large number were very excited and had to go into the refractory wards, so there was little doubt about the aggravation of it. Also a very large number died or were in a moribund state in a very short time, and that was why they had not been seen in civil hospitals. These men were kept in military hospitals rather than sent to civil asylums, and many went down in health rapidly. Another point—and this would interest Dr. Brunton—when the cerebro-spinal fluid was examined in many cases a large number of them had an enormous number of cells. He wondered what had been the general experience of repatriated prisoners. Quite a large number had turned out to have general paralysis—in fact some of their medical men wondered whether the Germans had been playing tricks. These men had been exposed to all sorts of privation and hardship—more than the average soldiers—and the great majority had a history of brutality, and these might constitute factors in the development. One thing had rather dismayed him—the large number of cases not recognised although they showed a great many of the symptoms. He quoted the history of one case; the doctors had noticed at different times all the symptoms, yet general paralysis never once appeared on the man's sheet until he (Dr. Ross) actually wrote it in himself. It was the worst case he had had. He thought it was rather appalling how very many general paralytics went about the world unrecognised by medical men.

Capt. LATHAM said that in Australia the serums of patients in temporary syphilitic hospitals were examined. The medical officers seemed sceptical of the result and asked him to do it again; apparently for some reason or other the incubation period seemed too short and most of the soldiers too young. In most cases the symptoms were very mild, and being very mild the medical officers doubted the diagnosis. In a certain number of cases where the cerebro-spinal fluid was examined there was no doubt—particularly in view of the quantity of globulin—that they had to deal with very serious lesions. In contradiction to Col. Dawson's experience, general paralysis was a very serious disease in Sydney and one of the most important causes of death in New South Wales. Their medical officers were well acquainted with it, and one was surprised with the suddenness of the symptoms needing certification. The onset was frequently too sudden for sclerosis, and it gave one the impression that they were suffering from toxæmia. As to the causation of general paralysis by syphilis, he said they had tried injecting animals with small quantities of spirochætes, and in a certain number of cases they had induced a condition resembling general paralysis.

Dr. COLIN, replying on the discussion, said they all agreed that alcohol besides syphilis must be a factor of general paralysis, but in war time they had not noticed the preponderating influence of alcohol. He was glad to see from an article in the last number of the *Journal of Mental Science* that Dr. Chambers had come to the same conclusion. A certain number of absolutely teetotal physicians were apt to come to false conclusions on this matter. Fever symptoms were so often like alcohol symptoms that care must be exercised not to confuse one with the other. He did not think the influence of alcohol in general paralysis was very great. He



was of Dr. Robertson's opinion that syphilis was the primary factor. He always felt that if it were the only cause of general paralysis, then men had not a right to a pension; but, though it was the primary cause, there were many others. He mentioned that he had had a case where only a few months intervened between re-infection and the onset of general paralysis. In reference to the case of returned prisoners, he had noticed that there were many instances of general paralysis, and it was horrible to think they had not been noticed while prisoners in Germany. The same lack of recognition of cases as had happened in England had also occurred in France, where general paralytics had been swept into the Army. He quoted the particulars of two typical cases, and said he agreed that in every country the knowledge of the ætiology of mental diseases was still in a backward condition.

#### MENTAL DEFICIENCY.

A REPRESENTATIVE meeting, convened by the Essex Voluntary Association for the Care of the Mentally Defective, which will lead to results of far-reaching importance, was held at River Plate House, Finsbury Circus, London, E.C. 2, on May 29th, when a large body of justices decided that a practical mental expert be appointed to advise Essex courts of summary jurisdiction on the mental condition of doubtful cases charged with crime. Above one hundred justices from Essex, Colchester, East Ham and Southend were present. The following is a summary of the speeches and the arguments brought forward:

The CHAIRMAN of the Essex County Council (Mr. W. S. Chisenhale Marsh), in opening the meeting, said that during the last fifteen or twenty years the practice of giving bail to persons had made it difficult to keep the mentally defective under observation. He had received a letter from the Magistrate at Westminster Police Court suggesting that remand homes were wanted for medical observation.

Mr. TREVOR, a Commissioner of the Board of Control, said: It will be remembered that the Report of the Royal Commission on the Feeble-minded stated that there were large numbers of defectives whose wayward and irresponsible lives caused an infinity of trouble and misery to their friends and themselves, entailing a great deal of wasteful expenditure on the community.

As the result of the Report of the Royal Commission the Mental Deficiency Act, 1913, was passed, which provided for the custodial care of defectives under very careful safeguards. Before much could be done in working the Act the war came, and, not unnaturally, any effective working of the Act had to be postponed. Now that, as is hoped, peace has returned, the Board of Control are urged by the Government to do all that is possible to encourage local authorities to work the Act. At the same time a Bill has been presented to Parliament to remove the limitation of the Government grant of £150,000 which had been inserted in Section 47 of the Act, and which had been allocated amongst the various local authorities in England and Wales on the basis of population. The result now is that local authorities will no longer be restricted by the limited amount of the grant allocated to them, but will receive half of all approved expenditure. It must not be thought that such a step indicates any reckless extravagance, for, on the contrary, it is hoped that an expenditure of money now will effect real economy in the future.

The general scheme of the Act is this: In the first place certain definitions are given of defectives, which include idiots, imbeciles, feeble-minded persons, and moral imbeciles. The circumstances are then set out which enable defectives coming within these categories to be dealt with under the Act. When any such defective is dealt with by order under the Act the local authority has the duty imposed on it of making provision for the case, and the Government contributes one-half towards the cost of its maintenance. The Act proceeds to impose certain duties upon local authorities, and also certain duties upon justices or judicial authorities when called on to make orders under the Act.

*Duties of local authorities: Ascertainment.*—Sect. 30 (a) of the Act provides that it is the duty of a local authority to ascertain what persons within their area

are defectives subject to be dealt with under the Act. This duty up to the present has only been partially carried out, and is complicated by the fact that a local authority has no duties in the first instance as regards defective children who are being dealt with by local education authorities, or defectives who are being dealt with by Poor Law authorities. The Royal Commission reported that there were some 150,000 defectives at large in the country, some 60,000 of whom were in urgent need of supervision. At the present time less than 10,000 defectives are being dealt with under the Act, and of these between three and four thousand were being dealt with under the Idiots Act before the Mental Deficiency Act came into operation. It is evident that a great deal still requires to be done in the direction of ascertainment.

*Accommodation.*—The local authority has also to provide suitable accommodation for persons dealt with under order. Speaking generally, in England and Wales but little new accommodation has been provided. Essex is more fortunately situated than most other counties, inasmuch as it is able to send its most pressing cases to the excellent Royal Eastern Counties' Institution at Colchester. It has also a call on the institutions of the Metropolitan Asylums' Board, which have been approved under Sect. 37 of the Act. The Board of Control think that the county will have to take steps to get more of the Poor Law institutions within the area approved under this section.

*Duties of Justices.*—In making orders for the detention of defectives under the Act very responsible duties are imposed on the justices, whether sitting in court or acting as judicial authorities under the Act. Many of the requirements of the Act are very complicated, but, in view of the serious consequences of the making of an order to the person affected, a certain amount of strictness is undoubtedly required. It has to be remembered that some of the cases in which justices will properly be asked to make orders are not easily recognisable on the view. Feeble-minded persons and moral imbeciles present some of the most difficult psychological problems, and in these matters it would be advisable for a justice not to depend on his own impression of the case but to be absolutely guided by the two medical certificates.

The ultimate success of the Act must depend on the completeness with which juvenile cases are dealt with. At the present time it is impossible to find institutions in which to detain all the adults who require protection. With the children, however, if they are duly reported by the local education authority before leaving school and are then dealt with by the Mental Deficiency authorities, good results should be shown in a comparatively short space of time. Complete co-operation is essential between local authorities, local education authorities, and poor-law authorities, and it appears to the Board of Control that in the case of a large county like Essex it would be very advisable to appoint a whole-time expert medical officer, whose duty it would be to advise and report on all cases occurring within the area of the county. The Board of Control are entirely in favour of the resolution which is about to be put to the meeting.

Sir H. BRYAN DONKIN, Director of Convict Prisons: I am glad of the opportunity of making a few remarks on this subject. The prison authorities, and especially the medical department, contributed largely by their repeated representations to the appointment in 1904 of the Royal Commission on the Care and Control of the Feeble-minded (of which I was a member), and this led up in time to Parliamentary action. More than twenty years ago, when I was appointed a Commissioner of Prisons, I was soon convinced of the necessity of a change in the law under which all more or less irresponsible offenders, except such as could be certified under the Lunacy Acts, had to be tried as ordinary criminals, and treated as such with respect to their discharge on licence or on expiry of sentence. The only really differential treatment they have even now consists in the fact that they have been for many years regarded and separately classified while in prison as weak-minded, and placed by the Commissioners under special medical regulations as to supervision, employment, and treatment generally.

The Royal Commission reported in 1908. It was not until 1912 that a Bill embodying a considerable part of its recommendations was introduced into Parliament. Opposed by vigorous parti-coloured criticism, it was withdrawn by the Home Secretary, and in 1913 another Bill, widely differing from the first in many important respects, became the present Mental Deficiency Act. This Act

has caused much disappointment among the supporters of the first Bill, and much tribulation among those who have to administer it, both medical and lay.

The remarks I am about to make in support of the resolution concerning the appointment of a specially qualified medical officer to assist the courts in dealing with suspected cases of "mental deficiency" are merely general, and are intended as a preliminary to the more practical information and comments which will be given to this meeting by Dr. Treadwell out of his long and up-to-date experience both as former prison medical officer and as a Commissioner. It is no easy matter, even for an expert, in some cases to decide justly whether any person of any age is mentally defective to such a degree as to be regarded and treated as more or less *irresponsible*, or, in other words, unfitted for such punishment as would be rightly awarded to the average sane individual. It follows that no action should be taken in the direction of deciding the question of any offender's mental condition without having recourse to an accredited medical opinion. But it is equally important that the courts or councils who may appoint such medical advisers should recognise fully that in a considerable number of cases it is impossible even for the most experienced practitioner to form a trustworthy opinion in *one* interview. This is a point of first importance, which Dr. Treadwell will illustrate.

I agree with those who urge that suspected "mental defectives" should not be sent to prisons for the purpose of obtaining medical opinions on their mental state. I have very good reason to be convinced that in the larger number of instances the opinions of the medical officers of prisons are of the highest value at the present time; but in a service which in some of the smaller prisons is supplied by local practitioners it is not to be expected that every one of them would take the responsibility of deciding on a case of patent difficulty. Moreover, it seems to be not fair that the suspected "defective" should be sent into a prison at all for the purpose of obtaining a medical opinion.

The existing difficulty as to the certification of mentally defective offenders is mostly due to the drafting of the Bill of 1913—now the Mental Deficiency Act. At the head of this Act are certain so-called "*definitions*" of the various grades of defect, and it is enacted that only those persons whose cases can be stated to come under these "*definitions*" are to be certified as mentally defective. These descriptions or interpretations of the words *idiot*, *imbecile*, *feeble-minded* and *moral imbecile* are generally taken to imply that in every certificate there must be evidence given that the alleged mental defect did exist from birth or from an early age. At any rate, such is the meaning seemingly placed upon this clause by the Board of Control; and such also is the way in which many, if not most, of the medical men called upon to certify, do actually read it.

It follows that this clause of the Act, interpreted as it is, and probably correctly interpreted as far as literal accuracy goes, demands a far more rigid, and, indeed, a far more impracticable definition of congenital mental deficiency than is required in the case of certification in lunacy by either the Board of Control or any court of law. As a matter of fact there is no definition at all of "lunacy" (*i.e.*, the *state* of lunacy) in the Lunacy Acts. It is true that in the glossary of the Lunacy Act, 1890, it is said that "lunatic" means an idiot or a person of unsound mind. This merely divides "lunatics" into two classes; but there is no attempt to say what is meant by either of the terms "idiot" or "unsound mind." I suppose, however, that most doctors in certifying take *idiot* to mean mentally defective from birth, and *unsound mind* to mean a disordered or defective mental state of a person whose mind has once been sound.

It was not the intention of the Royal Commission on the Feeble-minded, or, as I believe, of the framers of the Bill of 1912, to make the above-named so-called definitions *statutory* as they stand now in the Mental Deficiency Act, October, 1913, or to require that contemporary evidence must be obtained in all cases that the person to be certified was actually known to be defective in early childhood. This requirement is seen on reflection to be absurd. In a large majority of the cases with which the Mental Deficiency Act was meant to deal the diagnosis of the early origin of the defect, even without any contemporary evidence of it, is as sound and trustworthy as that of a large number of diagnoses made not only in lunacy, but also in many other departments of medical practice which of necessity are based to a considerable extent on analogy and inference.

I am forced to the opinion that this provision at least in the existing Act should



be altered, for it seems very unlikely that its present interpretation will become enlightened by the process of time alone. At present the claim in question is not only one example of the proverbial differences between medicine and the law, but it is also a stumbling-block for practitioners in each of these faculties.

Mr. O. F. N. TREADWELL (Prison Commissioner): I am very glad of the opportunity afforded me by the kind invitation of the Essex Voluntary Association to attend this meeting, and say a few words on the working of the Mental Deficiency Act, 1913, from the prison point of view.

We have had a good deal of experience during this past five years, particularly as regards the difficulties involved in certification, owing to the limitations imposed by the Act and of the delay, which appears to be unavoidable at present, in finding institutions to accept the cases.

As regards the difficulties of certification, these are probably more fully realised by those who have to deal with cases in prison than elsewhere, because it is the commission of some crime that accentuates the need for action. Practically all the cases we deal with are over the age of sixteen—many are adults; obviously they have always been mentally defective, but they have, before the commission of the offence with which they are charged or for which they have been convicted, escaped recognition, or at any rate certification. They are therefore evidently not obvious cases. It is, of course, the commission of some obvious offence which accentuates the need for institutional treatment, care and control.

Sect. 1 of the Act defines the classes of persons who shall be deemed defectives within the meaning of the Act. I need not refer to classes (a) or (b)—idiots and imbeciles. They seldom come to prison or present difficulty.

Class (c)—feeble-minded persons—differ very much in degree and kind, and many present much difficulty. There must be intellectual defect; but in cases where the defect is not of marked degree it is not always easy to say whether it is the result of developmental defect, or due to want of, or neglect of educational opportunity. Age has an important bearing. The older the person when coming under first observation, the more difficult it is to prove that the condition existed from birth, or from an early age. Very commonly they come for the first time under the observation of the medical officer of the prison. The early history of the case is generally essential; this necessitates research and delay. Most medical officers are extremely loath to certify without a full early history.

When we come to class (d)—moral imbeciles—our troubles really begin. This class is perhaps the most frequent and certainly the most troublesome met with in our prisons. Naturally this is so, because the definition connotes disorder of conduct, and it is for some disorder of conduct that they are brought before the courts and into prison. Where a moral imbecile is also a feeble-minded person the task of certification is of course easier. Again, certain offences of themselves indicate probable mental defect, but many of these moral imbeciles come in for offences such as are common to ordinary criminals. They frequently exhibit little or no intellectual defect, have attained a very fair education, and in prison, unless they are violent, destructive, or intractable, prone to self-injury, suicide or feigned attempts at suicide, may have no opportunity to demonstrate the particular quality of misconduct to which they are addicted. Perhaps the most prominent feature in this type is "lack of control," but it is not easy to say whether this is inherent in the individual. Age, again, is an important factor. Obviously they have always been mentally defective, but no action has been taken to deal with them until they commit crime, or repeatedly commit crime, and the urgency for action then becomes apparent.

The following case is a good illustration, perhaps, of the difficulty experienced. A young woman, æt. 20, charged with false pretences, tried at quarter sessions, found to be mentally deficient, ordered to be detained for twelve months in an institution, which, however, refused to receive her; returned and was liberated. Admission to another home was secured and she remained there some time, but was found to be unmanageable and released. Again brought up for larceny and sentenced to twelve months' hard labour. Certified under sect. 9 (1), (d), as a moral imbecile. Said to be cunning, plausible, vain, deceitful, very untruthful, and sullen if corrected. Has been troublesome since the age of seven years, when she ran away from home. Incurable, prone to suicidal attempts, but it is doubtful if they are genuine. Six convictions had been recorded against her since



the age of thirteen and a-half. Removed to an institution for mental defectives. After about a year licensed from there, the authorities reporting that under supervision she has behaved well, showing great restraint and self-control. A few weeks after again brought up for stealing and sentenced to twelve months' hard labour. In prison violent at times and further attempts at suicide. Re-certified, and again removed to an Institution.

In all cases the early history is very valuable; it necessitates much careful inquiry and research, and takes time to collect. I must take this opportunity of saying how much we are indebted to the Essex Voluntary Association for kindly placing at our disposal much valuable information as to early history in several cases from the county of Essex.

A few words as to Borstal detention for young adults. Borstal detention is not at all suitable for mentally defective persons. The Borstal institutions are for the express purpose of teaching occupations which shall fit the young delinquent for industrial life outside, and for reformation of character. Mental defectives are a source of much trouble; they tend to contaminate and corrupt the normal inmates. The Commissioners always strongly recommend to the courts that young persons suffering from mental defect should not be sentenced to Borstal detention.

And now as regards procedure when a case comes before the court. It is of the utmost importance, I think, that a mental defective should be dealt with by the court of competent jurisdiction under sect. 18 of the Act, rather than that a sentence should be passed with a view to action under sect. 9. Prison is not a suitable place for the detention of mental defectives if it can possibly be avoided. Dr. Potts will, I hope, tell us of the procedure which has been adopted at Birmingham, but I may say that the Prison Commissioners are endeavouring to co-operate with the Birmingham justices, by setting aside a portion of the hospital wings—both male and female—for the reception of such cases on remand as they are compelled to send into prison for observation and report.

It is intended to appoint a whole-time medical officer of the prison service in order that he may devote himself as part of his duty primarily to the examination of these mental cases. Where an expert medical practitioner is appointed with whom the justices can confer, very valuable co-operation and consultation can be arranged between him and the medical officer of the prison in certain cases which for some reason or other must be remanded to prison.

In conclusion I should like to say a few words as to the use of prisons as "places of safety" under the Act. If it is admitted that prisons are unsuitable for the detention of mental defectives, they are unsuitable for use as "places of safety." Unfortunately there is often much delay in finding an institution to take the case; consequently the court cannot make an order, but directs that a petition be presented when an institution has been found, as provided for in sect. 8. A mental defective may thus be detained in prison for some time—perhaps two or three months. If no institution can be found, the person cannot be kept indefinitely and has to be discharged. No doubt as institutions increase in number and become available, this will be rectified.

I have perhaps said sufficient to indicate how important it is to have expert medical advice available at the trial of these mentally defective persons, and I can cordially support the resolution which is to be submitted to this meeting.

W. A. POTTS, M.A., M.D. (Medical Officer to the Birmingham Committee for the Care of the Mentally Defective; Psychological Expert to the Birmingham Magistrates): During the war many authorities refrained from carrying out their duties under the Mental Deficiency Act owing to the necessity for economy. That reason for delay is now happily removed. As a matter of fact, however, it never was an economy to ignore defectives who ought to be segregated. If you reflect that 15 *per cent.* of all persons in prison are mentally defective, that 30 *per cent.* of those in rescue homes are equally irresponsible, and a similar number of the women in the maternity wards of the workhouse are of the same type, it requires no great effort of the imagination to see that leaving these cases uncared for really means keeping up more institutions and a larger staff of attendants than would be required if such mental defectives were properly cared for from the first in a suitable institution. Often during the war a mother, who might have been working at munitions, was forced to stay at home to look after one defective child, when one attendant

might have been looking after ten defectives in an institution. Even if neglecting these cases meant economy now, it certainly does not mean anything of the kind for future generations. It has been estimated that one criminal, the notorious Ada Juke, known as "Margaret, the Mother of Criminals," cost the United States 1,300,000 dollars, owing to the fact that of her twelve hundred direct descendants, nearly one thousand were criminals, prostitutes, paupers, inebriates, or insane. A similar woman cost the Germans much the same sum; of the German woman's direct descendants seventy-six were convicted of crime and several of murder.

One fallacy in connection with defectives is the idea that anyone can recognise them. This is due to many people thinking only of idiots, and overlooking the two higher grades, the imbeciles and the feeble-minded. These higher grades have a greater potentiality for harm, and are a much more numerous class. Often only doctors with special experience can recognise them. Not only do ordinary people fail to see them, but often ordinary doctors do so, too; it is essential that they should be examined by a medical practitioner who has had special experience of such cases.

One reason why defectives are often overlooked is because many people do not understand that mental defect is a disorder, not of the intellect, but of the mind; intelligence is only one province of the mind and may be unimpaired in mental defect; the diagnosis rests on disorder of conduct and lack of adaptability to the environment.

How then are magistrates to recognise such cases? They cannot be expected to diagnose them. What they should do is to refer to their expert all cases they do not quite understand, especially when frequent repetition of the same offence, unusual offences, or offences inconsistent with the home and general upbringing of the delinquent, suggest the possibility of mental defect or some other abnormality.

The medical examiner will never get all the cases he ought to have under the Mental Deficiency Act unless some such scheme is adopted as that recently inaugurated by the Birmingham justices, for which we are so greatly indebted to their chairman, Mr. Beesley. Under this scheme are referred not only the obviously mentally defective, but also those in whom there may be such a defect. This scheme has already been the means of saving from prison young delinquents who ought never to go to prison, because their crime is the expression of some mental or physical abnormality which can only be properly dealt with in other ways. Cases referred by the magistrates because the cause of crime appears to be a complete mystery are not necessarily hard to understand when the prisoner is thoroughly examined, and especially when methods are employed to see how far mental and physical abnormalities, unsuitable occupations and surroundings are responsible. Modern treatment can work wonders in many of these cases.

Mr. JAMES TABOR (Chairman of the Essex County Committee for the Care of the Mentally Defective), proposed the following resolution:

"That this meeting, realising the necessity of expert medical opinion in doubtful cases under Section 8 of the Mental Deficiency Act, 1913, brought before courts of summary jurisdiction, requests the Standing Joint Committee to consider the provision of such expert medical assistance for all Petty Sessional Divisions in the administrative County of Essex."

He said that, owing to the war, the activities of mental deficiency committees had been much restricted, but that possibly that had not been a bad thing for them, as they were, so to speak, on probation, and could not have been as successful as they had been if they had not carried public opinion with them. This he believed they had done, and that now, with the cessation of hostilities and the issue by the Board of Control of the circular of March 8th, 1919, they were ready for greater exertions, and that any steps that they took would be supported by the public, even to the extent of asking for further legislation, if necessary, to carry out their programme. During the war they had concentrated their attention chiefly on the children passed on to them by the Education Authorities, but now they would be in a position to deal with adults also—a most important branch of their work. To enable this to be done efficiently, magistrates, before whom many mentally defective persons came, should be able to call in the assistance of a medical expert where there was any doubt as to the best method of adjudicating upon their cases in their own interests and in those of the community, for it was the high-grade defectives—

defectives as to whose mental condition only an expert could speak definitely—who were the greatest danger to the nation, and should be put under efficient control that the supply of mental defectives in future generations might be cut off at the source. He therefore trusted that the meeting would support the resolution then and there, and that such of them as were magistrates would make full use of the expert, if and when appointed.

Capt. A. J. UNETT, D.S.O. (Chief Constable of Essex), seconded the resolution which was passed unanimously.

Since the above report was in print we have received the following contribution from Dr. Edgar Hunt, which we add with pleasure as a supplement to the report.  
—Eds

#### SOME NOTES

on a representative meeting, convened by the Voluntary Association to discuss the administration of the Mental Deficiency Act (with special reference to criminal defectives), and held on May 29th last at River Plate House.

By EDGAR A. HUNT, J.P., M.R.C.S., L.R.C.P., L.S.A., Medical Visitor to the Justices under the Lunacy and Mental Deficiency Acts for the county of Essex and the Borough of Colchester, Chairman of the House Committee of the Royal Eastern Counties' Institution for Idiots, Imbeciles and the Feeble-minded, etc.

I will deal first with the main resolution, which was proposed by Mr. Jame Tabor and carried unanimously, *vis.*, "That this meeting, realising the necessity of expert medical opinion in doubtful cases under section 8 of the Mental Deficiency Act, 1913, brought before courts of summary jurisdiction, requests the Standing Joint Committee to consider the provision of such expert medical assistance for all petty sessional divisions in the administrative county of Essex."

When I voted for this resolution I was under the impression that what was intended was the appointment of one mental expert for the whole county—a new whole-time official—a medical man, if possible, somewhat after the style of Dr. Potts, of Birmingham.

But a circular letter of Miss Nevill—the excellent and indefatigable organising Secretary of the Essex Voluntary Association for the care of the Mentally Defective—dated July 3rd, states "until after the appointment by the various benches of a court doctor, who is a practical mental expert, etc.," surely it is not for a moment contemplated that a mental expert is to be appointed for each bench of magistrates! Real mental experts are few and far between. In the old days before the Mental Deficiency Act was passed—in the course of an extensive general practice extending over a long period—I used to be astonished at the ignorance of medical men generally about mental disease. Again and again they refused to sign certificates under the Lunacy Act when there was no doubt a certificate should have been signed in the interest of both the patient and the public. I wonder disasters have not been more frequent than they have been owing to this unreasonable refusal to certify. Heaven knows there have been many more than there ought to have been; and where there has not been disaster there has frequently been a large amount of sorrow, distress, worry and expense to the relatives which they might and ought to have been spared. If there was difficulty in getting cases certified under the Lunacy Act, there is ten times as much difficulty under the Mental Deficiency Act—this was well brought out and ably commented on during the meeting. I do not hesitate to say that under present conditions the usefulness of the Mental Deficiency Act is being much impaired because of the inability of numbers of medical men to deal adequately with the cases brought before them. I am not in a position to judge how mental defect is now being dealt with at the various schools of medicine. I entered at St. George's in 1874, and in my time the education imparted to students in mental disease was lamentably inadequate. It is obvious that a special training is now required to enable students to act at all properly in the carrying out of the Mental Deficiency Act when they become qualified. It may be such training is being given, and I hope it is. How necessary it is is shown by a single case of much interest which came under my notice in one of my recent official visits. The lad concerned is undoubtedly feeble-minded, and has been classed as such by one or two experts. He is a section 8



case, and an appeal is impending. In connection with the necessary legal proceedings several medical men have been consulted, and no less than four of them—and some of them were medical men of considerable standing—have definitely certified that the lad is not feeble-minded. When in doubt classify the case as “backward” is a frequent refuge for the inexperienced practitioner. They fail to see *why* the patient is “backward”—fail to see that he (or she) is “backward” because of mental defect. The mental expert appointed to guide the justices must be a really able, capable and practical man, one whose opinions must be sound, and whose decisions must be able to stand even very hostile criticism. I hope the folly—if it is contemplated—of attempting to find a mental expert in every petty sessional area will be nipped in the bud. I trust that one mental expert, in the true sense of the word, may be appointed for the whole county. He would necessarily act rather on behalf of the authorities; the medical visitor to the justices must continue to exist and must act rather on behalf of the public, and while he must do his best in every way to promote the beneficial working of the Mental Deficiency Act, must never lose sight of the “liberty of the subject” side of the question.

“A boy may not be able to make a good Latin verse, but nevertheless he may be able to make a very good table,” was one of the many pithy sayings of my famous headmaster, the late Edward Thring, of Uppingham. Now, there are some such boys (and girls) in institutions, and their cases call for very special consideration. I come now to that most important point, *viz.*, the provision of some suitable place (or places) in the county where mental defectives can reside when allowed out on licence—when allowed out on probation for varying periods provided they are kept under proper care, supervision and control. In many cases we have found that the home accommodation of such cases is utterly inadequate, that while it was very right and proper these cases should be allowed out on probation, it would be worse than useless to allow such cases to spend their period of probation at home.

I have in my mind an institution to which lads are sent who have been guilty of some crime—frequently some *very trivial* offence, and have been dealt with under Section 8. A good many of these lads are high-grade feeble-minded; some of them are undoubtedly cases of “late development”—a subject which requires an article to itself, and that not a short one if full justice is done to it; the majority have not had a chance—bad parents, bad homes, their start in life has indeed been a poor one. Many of these lads—these “street arabs”—are embryo hooligans of a bad type. But not all—very far from it. And it is not right that all who have been found mentally defective in some degree should be condemned practically to “imprisonment for life” after committing some trivial offence. The mental enthusiast might say they are to have the benefit of “life-long care.” “The man in the street” protests against them being “shut up” for life.

Now, in such an institution as the one I am referring to there is a small proportion of cases which ought to be given every chance to prove themselves worthy of freedom and to regain their liberty—perhaps not as *perfect* mentally, but who nevertheless may make useful law-abiding citizens and wage-earners.

It is obviously no easy matter to find anyone who is mentally *perfect*. That may seem a startling statement, but the mentally *perfect* would possess the talents of a senior wrangler, a senior classic, and a master of every subject calling for the exercise of brain power! Where is such a person? A certain proportion of defectives if given a fair chance may become useful members of society. I am fortunate in having had to work with a number of justices and lady visitors who are all reasonable and level-headed and who are not “cranks.” Many of these are sure that the question of the continued confinement of certain cases will be raised before long in the House of Commons. It is a matter of some surprise to myself that some of those who opposed the Mental Deficiency Act—rabid cranks on the question of the “liberty of the subject”—have not already caused a stir in the legislature about such cases as those I am dealing with.

It is everything for all concerned in the working of the Lunacy and the Mental Deficiency Acts to have “public opinion” with them—to have the support and sympathy of the public. And I must say in Essex we have been successful in obtaining this. At last interest in the subject has been aroused, and the general public recognises the necessity for, and the advantage of, the Mental Deficiency Act.

A few suitable cases—now confined—should be allowed out on probation, and there



should be a "half-way house" between confinement and liberty—possible ultimate liberty, of which cases should have the opportunity of proving themselves worthy. My idea is such "probation home or hostel" should be the residence of the medical mental expert for the county, that he should have under him a resident head attendant and head nurse for the male and female sides. To this hostel could be sent those borderland difficult cases, on the mentality of whom it is *impossible* to decide at a single interview. To this home cases could be sent on remand; they would be under supervision possibly for some time, and after the decision about their mental state had been arrived at, that decision could be reported to the justices before whom they had come in the first instance.

This hostel should be a real training home in which males and females could be taught what they were found to be most fitted for, and by the practice of which they might be able to earn a living. As they made good progress they would gradually be allowed more and more liberty. The period of probation would be renewed and extended, but all the while, until discharged, the certificates would hold good, and in case of necessity—for breaches of discipline, insubordination, misconduct or for other reasons—the cases could be sent back to where they came from or to institutions thought perhaps more suitable for their particular grade, to continue in confinement.

The finding of a suitable "guardian" for these cases on probation is an extremely difficult matter. There is a "Society for the After-care of the Insane"—there does not seem to be one "for the after-care of the feeble-minded." It seems to me here is a large field for voluntary philanthropy, if the State cannot at present undertake the matter.

But I hope an amended Act will insist upon the provision of such "half-way houses" by the local authorities.

By such an Act visiting justices ought to be invested with similar powers to those they possess under the Lunacy Act—"but that is another story."

#### DEATH OF DR. MERCIER.

##### CRIMINOLOGIST AND PHYSICIAN.

In Dr. Charles Arthur Mercier, whose death occurred at Bournemouth yesterday, the world of medicine in the department of psychiatry loses one of its most brilliant and distinguished ornaments. A subtle dialectician, a keen and logical debater, a psychologist, and a philosopher, he was also a practical alienist physician.

Of Huguenot extraction, and the son of a clergyman, he spent his early life in Scotland, and he owed much to a capable and generous-minded mother, to whose memory he was always unflinchingly loyal. The family being left badly off on his father's death, he joined a ship's crew and went to Mogador, and afterwards entered a woollen warehouse in the City. He then took to medicine, and from the outset of his career as a student in the London Hospital he was marked for success. His high graduation at the London University, together with his obtaining of the Fellowship of the Royal College of Surgeons, seemed to foreshadow distinction for him in the more purely practical aspect of the medical profession, but the bent of his mind was towards introspection and analysis. His great admiration for Spencer, the philosopher of evolution, and his devotion to his teacher and friend, Dr. Hughlings Jackson, led him to study mental diseases and neurology. He gained an extensive as well as an intimate and accurate knowledge of insanity in its various aspects by holding the post of medical officer in two large public asylums—the Bucks County Asylum and the City of London Asylum at Stone—and until the last few years he was the resident physician of a private asylum near London, where he was the personal and devoted friend of the patients under his care. He was greatly attracted to the legal aspects of mental diseases, and the quality of his mind might best be described as forensic and analytic. His stern logic led him at times to appear to over-advocate a weak claim. Dr. Mercier was essentially the champion of the weak against the strong. It was through his support and strenuous advocacy that a Bill was more than once introduced by Lord Halsbury, then Lord Chancellor, into the House of Lords to legalise the

treatment of insanity in its incipient stages, for insanity was only too well known to Dr. Mercier to be curable indirectly in proportion to its duration. He continued to urge with unremitting persistence the necessity for increasing the number of the scandalously overworked Lunacy Commissioners.

An effective speaker, Dr. Mercier might have attained even greater distinction in the legal profession than that which he achieved in psychiatric medicine. He was an invaluable member of a deputation, for his cold convincing logic could be relied upon in the face of countless difficulties to justify his point or to prove his argument. Those who were favoured with his confidence appreciated his striking independence, his clear intellectual ability, and his strong moral nature. His friendship was real for those he liked, even when these disagreed from him. His unflinching courage made him a strong opponent, yet, unlike many combatants, he had no venom in his nature. In debate he was as often effective by a humorous exposure as by his uncompromising logic. As a writer he was clear, incisive, and accurate—almost a purist in the use of the English language. He was as widely known in America as he was in this country, and a visit he paid to Boston a few years ago brought him an enthusiastic welcome from the charmed circle of lawyers, medical men, and literary critics of the American academic world.

Dr. Mercier's most intimate work for the benefit of the insane was chiefly known to mental experts, who were his colleagues on the Council of the Medico-Psychological Association, as well as on its Parliamentary and Educational Committee, where his special qualities were most valued and appreciated. Some time back he served as President of the Medico-Psychological Association as well as of the Psychiatry section of the British Medical Association Congress at Oxford. He was a member of the Departmental Committee in regard to the treatment of inebriety, and he gave expert evidence before the Royal Commission on the Care and Control of the Feeble-minded as the representative of the Royal College of Physicians of London. Like his teacher, Herbert Spencer, he had a great power of generalisation based upon a wide acquaintance with biology and the natural sciences. Besides special text-books upon psychology, he contributed articles to medical and other periodical literature as well as to various encyclopædias and dictionaries. He also contributed a number of letters to *The Times*. London University (for which he was examiner in his special subject) awarded him the degree of Doctor of Medicine in Mental Diseases, accompanied by its gold medal for special merit. He was a member of many learned societies, and he took a particular interest in the work of the Medico-Legal Society. He was a Fellow of the Royal College of Physicians. It was only last January that the Swiney Prize was awarded to him for his work on *Crime and Criminals*; this was the second time that that honour had been conferred on him, for ten years ago he won it for his book on *Criminal Responsibility*. In 1910 he stood, though unsuccessfully, for the Waynflete Chair of Philosophy at Oxford, and soon afterwards his *New Logic* appeared, a volume in which he attacked what he conceived to be Aristotelian logic with great vigour, but with an insufficient comprehension of the subject. Indeed, logic, both theoretical and practical, was not always his strong point, logician though he claimed to be; and in his miscellaneous writings, outside his own special subjects, there were occasional faults of reasoning. But in a comparatively short life he did a prodigious quantity of hard, intellectual work, and his interests were so many that it is not surprising if in his *parerga* his pen sometimes ran away with him.

He was married, but his wife predeceased him for a number of years, and he has left no family.

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A correspondent writes:

Might I be allowed to add a note to your obituary notice of Dr. Mercier? Dr. Mercier was twice married. His first wife died a considerable number of years ago. In 1913 he married Miss Mary MacDougall, whose early death in 1915 was a severe blow to him, coming as it did at a time when the progressive failure of health which marked the last fifteen years of his life had reached a stage which would have quelled a less robust spirit. Since then he had been living more or less in seclusion at Bournemouth. But physical infirmity was never able to damp his intellectual ardour. Practically bereft of sight and hearing, he none the

less kept up his literary and speculative interests, and only a few weeks ago was writing to a friend of a new book that he had a mind to write. His intellectual zest and keenness were undimmed. His death was quite unexpected, and was due to pleurisy contracted at the end of last week.—*Times*, September 4th, 1919.

### EXAMINATION FOR NURSING CERTIFICATE.

#### *List of Successful Candidates.*

#### FINAL EXAMINATION, MAY, 1919.

*Chester County.*—Margaret Langton, Edith Taylor, Beatrice Lewis, Edith Emily Williams, Betty Williams.

*Cheshire, Macclesfield.*—Cecilia Moore, Minnie Wigglesworth, Elizabeth Ellen O'Connor.

*Cumberland and Westmorland.*—Ethel Mary Howe.

*Dorchester.*—Beatrice May Message, Anna Hennessey, Dorothy Isabel Evett, Annie Maud Mary Atkins, Agnes Bridget McDonnell.

*Essex, Severalls.*—Mabel Blanche Button, Evelyn Gray, Florence Reddiford, Mabel Gertrude Taylor.

*Glamorgan, Bridgend.*—Catherine A. Thomas, Muriel Owen, Bridget Alysions Neville, Winifred Elinor Preece.

*Kent, Barming Heath.*—Hannah Helene E. Hardingue, Eva Gladys Wood, Phyllis Mary Evans, Gladys May Bishop, Hannah J. Kirby, Veronica Mawdsley, Laura Violet Killian.

*Kent, Chatham.*—Mary Hotton, Amy A. Wellard, Mary Angus.

*City of London.*—Ethel Florence Tucker.

*Cane Hill.*—Mary Connell, Rose Elizabeth Martin, Daisy Ella Martin, Elsie May Payne, Harriette May Paull, Nellie Louisa Mary Perrey, Gladys Garrood Smith, Leelia Kearney.

*Hanwell.*—Isabella Davies, Marie Plumb, Minnie Elizabeth Lelean, Louise Scott.

*Long Grove.*—Rose Alice Ethel Message, Annie Jane Jones, Honoria Martha Byrne, Lilian Margaret Blythe, Albert James Ring.

*Colney Hatch.*—Alice Taylor, Nora Annie Coles, Myra Compton, May Good, Margaret K. M. Westcott, Jessie Myrtle Bingham.

*Banstead.*—Winifred Constance Bright, Phyllis Stribbling, Elizabeth Rose Neighbour, Lucy Jordan, Margaret Priscilla Day, May Gladys Waylan, Florence Ada Devey, Lucy Eleanor Pownall, Jessie Elsie Dawson.

*Fountains Temporary.*—Jessie Macdiarmid, Edith Morrison.

*Napsbury.*—Annie Laundon, Lucy Downes, Elsie G. Rogers, Ethel Mary Davis, Annie Keziah Richardson.

*Notts County.*—Florrie Leeson, Annie Gamble, Betsey Todd, Irene Ethel Godber.

*Shropshire County.*—Frances Nellie Dodd.

*Staffs, Burntwood.*—Annie Gibson.

*Staffs, Cheddleton.*—Mary Ellen Watters, Gladys Ethel Chaplin, Charity Elinor Rooney, Mary Frances Coyle.

*Sussex, Hellingley.*—Ada Kathleen Redfern, Rose Brett, Bertha Elizabeth Miles, Margaret Mary Clarkson.

*Worcestershire, Barnsley Hall.*—Harry Milhouse Storr, Frank Walton, Ellen Lee Tomkys.

*Birmingham, Winson Green.*—Emma Benton, Rose Adelaide Shilcock.

*Hull City.*—Maude Miller, Agnes Senior, Annie Hunt, Jenny Bate, Emmeline Grayshon, Annie Kirby.

*Leicester Borough.*—Mabel Wakefield, Isabella Catherine Johnston, Lillian Soar, Edith King.

*Notts City.*—Blodwen Davies, Jane Riley, Daisy Branston.

*Sunderland Borough.*—Ronald W. G. Dean, Mary Hewitt.

*York City.*—\*Elizabeth Rains.

*Norwich City.*—Winifrede Alice Mayes.

*Bethlem Hospital.*—Rose Amelins Huss, Alice Maud Martin.

- Bootham Park*.—\*May Boyes, Mary Black, Christina Watt, Florence May Mitchell, \*Amy Walker.
- Brislington House*.—Miriam Andrews, Mabel Elizabeth Doling.
- Camberwell House*.—Lillian Bateman, Jessie Webster, Gertrude Izod.
- Coton Hill*.—Mary Vincent.
- Middleton Hall*.—Muriel Chesher, Ada Bruce.
- St. Andrew's, Northampton*.—Ralph Leonard Haynes, Ralph Neal Easton.
- Ticehurst*.—Louisa Ford, Martha Wootten, Emily Charlotte Fry, Ivy Victoria Holtham.
- Warneford, Oxon*.—Evelyn Emily Swadling.
- York, Retreat*.—\*Margaret Emily Wilmot, Ethel Barbara Davison.
- Aberdeen Royal*.—Williamina Burr, Elizabeth Anderson, Annie J. E. Gordon, Florence Watson.
- Aberdeen District*.—Mary J. Gerrard, Jessie S. Roy, Florence Stephen, Catherine Crichton, Leslie D. Duncan, Lily J. Reid, Mary A. Thomson, Helen McLean.
- Ayr District*.—Janet T. McCulloch, Jane B. McKellar, Elspeth G. Kirkwood, Donald Cowan, David Reid, George Burns, Agnes Shankland Malloch, Janet Sutherland MacKenzie, Jane Fulton White, Agnes Bain Haig, Margaret Mathieson, Agnes Boyle Cowan.
- Banff*.—Jennie Murray Burnett, Maggie Ann Stewart, Susan Mackintosh.
- Crichton*.—John Laurie Campbell, William Francis Farrington, Mary Campbell, Mary MacFadyen, Mary Tait, Sarah Johnstone McLean, Rebecca McQuarrie, Maggie Gordon Matthew, Adelaide McAdam, Mary Ann Waite Starkey, Elizabeth Jane Beaton, Lena Ellen Weston, Molly Graham, Margaret Eliza Kennedy, Jean Johnstone Ross, Jean Quinn, Mary Fraser Edgar, Annie Mary Weir.
- Gartnavel*.—Betty Orr, Catherine Cameron, Mary Mackenzie, Ethel Ellen Ferguson, Catherine T. Robertson, Molly McCann, William Arrol.
- Gartloch*.—Flora Robertson, Christina MacAskill, Margaret Findlay, Morag Kennedy, Janet McK. Shennan, Isobel McC. Parker, Catherine Campbell Galbraith, Kathleen Connolly, Margaret Grey Summers.
- Woodilee*.—Helen Horn Brown, Jessie Ann Cook, Agnes Cowie Hamilton, \*Georgina H. Wilson.
- Craig House*.—Kathleen Chisholm, Mary Cochrane, Ruby Swanson.
- Edinburgh Royal*.—Elizabeth M. Ewing, Mabel Brown, Muriel M. Pond, Margaret Weir Fleming, Janet Williamson, \*Ina M. Nicolson, Maggie C. Dower, Jessie W. Johnstone.
- Elgin District*.—Isabella Hadden, Ann B. Strathdee, Lily L. Taylor.
- Hawkhead*.—\*Jeannie Lovie Corbett, Isabella K. Russell or Macdonald, Dorothy Dawe.
- Lanark*.—Elsie Campbell, Jean McHardy, Mary McHattie, Annie McLaughlin, Catherine Smith.
- Midlothian and Peebles*.—Mary Keith, Agnes G. Lemmon.
- Melrose*.—Margaret Webster.
- Montrose Royal*.—Williamina Denchar Allan, Janet Crombie, Isabella Jane Ferrier, Matilda Neave Guthrie, Robina Canning McKay, Jane Nicolson, Alice Smith, Margaret Charlotte Sutherland, \*Margaret Tierney, \*Rachael Smith.
- Murray*.—Elspeth Hazel Macdonald Baillie, Helen Sharp Brown, Elizabeth Maclean, Jean R. C. Buchan.
- Riccartsbar, Paisley*.—Mary B. Morrow, Elizabeth Jane Dawson, \*Jane Bishop Alexander.
- Mullingar*.—Joseph Farrell, Cecilia McDonnell, William Flanagan.
- Omagh*.—Maria Haddon, Isabella Mary Gay, Margaret Lynn, Mary C. Morris, Mary McGonagle, Catherine Bella McNulty, Bridget Sweeney.
- Portrane*.—Margaret Gilmartin, Catherine Tighe, Patrick Healy.
- Richmond*.—Elizabeth Dalton, Martha Connell, Michael Purfield.
- St. Patrick's*.—Ida Jorleson, Thomas Mullarney, Michael Joseph O'Neill.
- Fife and Kinross*.—Johan McDonald, Catherine Fraser Wilson, Angusina Murray Rhind, Jessie Ann Taylor, Agnes Gordon Robertson, Esther Stark, Marion Waddell Coffield.
- Warwick County*.—Dela Everall, Evelyn Rochford.

\* Passed with distinction.



## PRELIMINARY EXAMINATION, MAY, 1919.

- Cumberland and Westmorland*.—J. B. Ferguson, E. B. Smith, S. Tracey, J. Hardy, O. L. Sainty.
- Chester County*.—F. Carman, S. Bretherton, E. Mackay, E. O'Keefe, E. Walley, N. Hiron, D. Price, M. H. Jones.
- Macclesfield*.—L. Newbold, J. R. Lyne, E. M. Clewlow, H. A. Belfield.
- Dorset County*.—W. T. Hunt, H. F. Fox, K. Riglar, F. Dean.
- Essex, Severalls*.—J. T. Harper, E. Wilson, D. Wilson, E. Taylor, M. Smith, E. M. Pullen, G. Morgan, E. Kenyon, H. Henfrey, J. Hudson, R. A. T. Grant, E. M. Denley, D. G. Deary, E. M. Calver, A. E. Bailey, E. A. Barton, M. Arthur.
- Essex, Brentwood*.—W. L. E. Kennard.
- Glamorgan, Bridgend*.—B. Bowen, L. Davies, M. John, L. Jones, A. Roberts, G. Vaughan, C. A. Davies, G. M. Richards.
- Isle of Man*.—E. M. Kelley, A. L. Knight.
- Barming Heath*.—M. E. Shaw.
- Claybury, L.C.C.*—L. Clare, M. B. Hyland, E. Godden, W. Roberts, E. Redden.
- Cane Hill*.—J. A. Ishmael, C. Moran, G. M. Rumble, D. M. Drake, R. A. Fraser, S. T. Wilson, A. M. Purdy, D. L. Skelton, A. Keating, B. Croxford, D. T. Shepherd, M. C. Jones.
- L.C.C., Hanwell*.—M. Baker, A. Frost, A. Turner, A. L. Lear, J. Jones, D. Granger, E. B. Sawyer, L. Archer, H. Vernon.
- L.C., Colney Hatch*.—L. K. Gentry, A. L. Downs.
- L.C., Banstead*.—L. Maguire, A. McBrien, A. Crowe, K. O'Shea, J. M. Hurley.
- L.C., Long Grove*.—M. A. Barry, M. G. Burns, G. M. Howell, C. M. Povey, L. Stevenson, S. T. Williams.
- Notts City*.—L. McGuinness, M. L. Barrett, H. Coope, J. M. Glennon, M. A. Jourdan, N. Wolgate.
- Shropshire County*.—E. Bray, L. Morgan.
- Surrey, Netherne*.—N. C. Brown, D. M. Pitman, A. L. Ward, H. Bakewell.
- Sussex, Hellingley*.—G. F. Bath, A. M. Tanner, F. B. K. Knight, F. M. Shonk, H. Peddle, J. F. Challenor, B. McPartland, N. Nuttall, N. F. Fahy.
- Worcester, Barnsley Hall*.—L. Clifton, D. W. Wilson, W. L. Porter, G. M. Licence, R. Burton, J. W. Durrant, W. L. Griffiths.
- Yorks, Storthes Hall*.—A. M. Duffield, T. Reddick, A. Sharpe.
- Winson Green*.—C. C. Griffiths, B. Bosworth.
- Derby Borough*.—Dora Twigge, Evelyn W. Lee.
- Brighton Borough*.—C. L. Thomson, B. M. Fidler, E. Ayres, R. J. Wingrove, K. E. Clifford, F. Phillips.
- Leicester Borough*.—E. M. Griffin, A. Hurren, H. M. Babb.
- Hull City*.—J. W. Ellerker, J. Hemmingway, M. Hardie, R. Nicholson, J. Richardson, M. L. Willoughby, L. Rowley, B. A. Patrick.
- Norwich City*.—M. E. Wilson, L. Sturman, F. M. J. Tooke, C. M. Holland, C. E. Gould, F. G. Garland, H. E. M. Foster.
- Sunderland Borough*.—M. E. Bailey, J. Collins, K. Edwards, M. Fagan, G. Goodings, C. Lawson, A. G. Press, J. Pybus, E. M. Wanless.
- York City*.—F. M. Swift.
- Caterham*.—G. L. Potter, H. C. Woodward.
- Leavesden*.—G. M. Howes, D. M. Maycock, C. E. Pulford, G. F. V. Fry, S. Rowney.
- Bethlem*.—K. A. Hughes, W. D. Tindall, M. King, N. Waite, M. Tweeddale, C. Gill.
- Bootham Park*.—J. C. Warren.
- Brislington House*.—E. G. Fynes, E. M. Matthews.
- Camberwell House*.—W. J. Witts, A. S. Prince, H. E. Buckley, D. G. Pears, E. Rowlands, G. M. Haynes.
- Coton Hill*.—H. Somers, D. Taylor, G. Hodson, F. Heathcote.
- St. Andrew's Hospital*.—W. E. Isom, E. E. Munday, B. O. Goode, O. Gibbons, N. Buckley, M. J. Browne, M. A. Leslie.
- Warneford, Oxford*.—E. M. Dean, G. J. Harris, H. Davies, F. C. Redding, J. A. Tutty.

- Aberdeen Royal*.—J. Duncan, A. M. Fraser, J. Sorrie, A. Duncan, A. Davidson, L. E. Milne.  
*Aberdeen District*.—A. B. M. Milton, J. G. Wilson, J. S. Beaton.  
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